Bundle LCHG Board Meeting in Public Session 3 March 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

2.1 Ward Accreditation - Intensive Care Unit, Lincoln County Hospital
Deputy Group Chief Nurse

2.2 Celebrating Group Success - Black and Asian Maternal Health Group
Deputy Group Chief Nurse

2.3 CNST Annual Board Declaration
Deputy Group Chief Nurse/Head of Midwifery

Item 2.3 CNST Front Sheet
Item 2.3 Appendix 1.0- CNST MIS Year 7 End-of-year compliance position report V1.1 30012026 FINAL
Item 2.3 Item 4.1.7 App 1.1 CNST Board Declaration
Item 2.3 Appendix 1.2- CNST MIS Year 7- SA1 Compliance report V1.3 27012026 FINAL

3 Apologies for Absence
Group Chair

4 Declarations of Interest
Group Chair

5 Minutes of the meeting held on 6th January 2026
Group Chair

Item 5 DRAFT Public Board Minutes Jan 26

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

Item 5.1 Public Board Action log Jan 2026

6 Group Chair Arrangements
Group Chair

Item 6 Group Chair Arrangements

7 Group Chief Executive Report to the Board
Group Chief Executive
Introduction of Resident Doctor 10 Point Plan Peer Doctor, Dr Arunpreet Sahota by Group Deputy Medical Director

Item 7 Group CEO update Public Board -March 2026 Final

7.1 Group Model Workstream Report
Group Chief Executive

Item 7.1 Group Model Closure Front Sheet
Item 7.1 Appendix Closure Work Programme as at 240225

8 BREAK

9 Strategic Aim 1 - Patients

9.1 Assurance and Risk Report from Quality Committee
Chair, Quality Committee

Item 9.1 Quality Committee Assurance Upward Report - January 2026 v 2
Item 9.1 Quality Committee Assurance Upward Report - February 2026

9.2 Finance Briefing
Group Chief Finance Officer

Item 9.2 Trust Board - Finance Briefing M10

9.3 Assurance and Risk Report from Finance and Performance Committee
Chair, Finance and Performance Committee

Item 9.3 Finance Committee Assurance Upward Report January 2026 v 1
Item 9.3 Finance Committee Assurance Upward Report - February 2026

10 Strategic Aim 2 - People

10.1 Assurance and Risk Report from People Committee
Chair, People Committee

Item 10.1 People Committee Assurance Upward Report January 2026 v Final
Item 10.1 People Committee Assurance Upward Report February 2026

10.2 Gender and Disability Pay Gap Reports
Group Chief People Officer

Item 10.2 ULTH Pay Gap Reports Cover sheet - Board - 03.03.26
Item 10.2 ULTH GPG 2025 - People Committee
Item 10.2 ULTH Ethnicity Pay Gap Report 2025 - People Committee
Item 10.2 LCHS Pay Gap Report Cover sheet - Board - 03.03.26
Item 10.2 LCHS Ethnicity Pay Gap Report 2025 - People Committee
Item 10.2 LCHS GPG 2025 - People Committee
Item 10.2 LCHG Action Plan Pay Gaps HIA 3 2026 v2

11 Strategic Aim 3 - Population

11.1 Assurance and Risk Report from Integration Committee
Chair, Integration Committee

Item 11.1 Integration Committee Assurance Upward Report January 2026 v 1
Item 11.1 Integration Committee Assurance Upward Report February 2026 v 1

11.2 Strategy Delivery Q3 Assurance Report
Group Chief Integration Officer

Item 11.2 FINAL Q3 Strategic Delivery Assurance Report v1

12 Integrated Performance Report
Group Chief Officers

Item 12 IPR Front sheet March Board
Item 12 Appendix Group Board M10

13 Risk and Assurance

13.1 Group Risk Management Report
Deputy Group Chief Clinical Governance Officer

Item 13.1 LCHG Risk Report March 2026
Item 13.1 Appendix A - LCHS Group Board High or Very High Risks March 2026
Item 13.1 Appendix B - ULTH Group Board High or Very High Risks March 2026
Item 13.1 Appendix C - LCHG Risk Appetite Statement 2025-2026

13.2 Board Assurance Framework
Group Director of Corporate Affairs

Item 13.2 BAF Group Board Front Sheet March 2026
Item 13.2 LCHG Group BAF as at 24.02.26

13.3 Assurance and Risk Report from Audit Committee
Chair, Audit Committee

Item 13.3 Audit Committee Upward Report January 2026

13.4 Amendment to Standing Financial Instructions
Group Director of Corporate Affairs

Item 13.4 Proposed Amendment to Standing Financial Instructions

13.5 Board Foward Planner

Group Director of Corporate Affairs
Information item

Item 14 MASTER Board Work Programme 2025-26

15 Any Other Notified Items of Urgent Business

16 The next meeting will be held on Tuesday 5th May 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.

NHS
Lincolnshire Community and Hospitals NHS Group

CNST Annual Board Declaration

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3rd March 2026*
Agenda item number	*2.3*
Report title	*CNST Annual Board Declaration*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Approval*
Accountable Director	*Nerea Odongo, Group Chief Nurse*
Author(s)	*Emma Upjohn, Head of Midwifery, ULTH*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	*Quality Committee*
Financial implications, if applicable	*Full achievement of all ten safety actions enables full recovery of the Trusts contribution and potential receipt of surplus funds, historically worth £600k–£800k.*
Action / decision required	*The Board / committee is asked to:* • *Approve the self-declaration submission and to authorise the CEO to sign the declaration*

Assurance Rating Key:

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

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

1c: Improve productivity and deliver financial sustainability	
1d: Provide modern, clean and fit for purpose care settings	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through training, development and education	
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

- Compliance with NHS Resolutions (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) requires full achievement of all elements within each of the ten-safety actions.
    - During routine evidence review, the Trust identified one eligible perinatal death that was appropriately managed and reviewed through local processes but was not notified to MBRRACE-UK within the required seven working days. This late submission represents non-compliance with Safety Action 1, as Standard A was not met, although Standards B, C and D were achieved. As compliance requires full achievement of all elements of the safety action, it is proposed that the Trust declare non-compliance with requirement one of Safety Action 1 and, as a result, will have to return of a submission of overall non-compliance for the MIS Year 7 scheme actions. Further detail can be found within the SA1 compliance position report (*appendix 1.2*)
    - The Trust can demonstrate compliance with the remaining nine safety actions as detailed within the year-end report.

- The year-end compliance report (*appendix 1*) and its accompanying appendices set out the Trust's position against all MIS Year 7 requirements alongside the upward reported position from the Quality Committee.

- It is presented to Trust Board with **request for approval of the intended submission of non-compliance and to authorise the Chief Executive Officer to sign the Board declaration** for submission to NHS Resulutions by **midday on 3rd March.**

- The Trust has an established governance process to support the end of year declaration submission process. In summary this consists of:

    - Oversight and assurance for the MIS reporting period are maintained through the Maternity and Neonatal Oversight Group (MNOG), chaired by the Group Chief Nursing Officer, with participation from Board Safety Champions, the Perinatal Leadership Team, the Group Compliance Team, and the ICB.
    - MNOG reports progress and issues to the Quality Committee, which in turn reports to the Group Board.
    - External assurance is provided through evidence reviews undertaken by the Group Compliance Team and the LMNS Lead Midwife on behalf of the ICB.
    - Both parties meet with the Director of Midwifery and the Maternity Safety Team to agree conclusions, leading to a recommendation on the content of the end-of-year CNST declaration.
    - The recommended end-of-year CNST declaration and accompanying position report have been submitted from MNOG to the Quality Committee for approval, before being upwardly reported to the Group Board.

- For Year 7, the Group CEO and the ICB Executive Director of Quality will meet on 24th February 2026, prior to the Group Board meeting, to scrutinize the assurances on the completed governance process and confirm they approve the use of their electronic signatures to be applied to the end-of-year CNST declaration.
- This remains subject to formal Group Board approval on 3rd March 2026, which is the same day as the CNST year 7 submission deadline.
    - The CNST submission timeframe is recognised to be extremely tight 17th February – 3rd March, providing limited flexibility.
    - If permission is given the Group Compliance Team/Maternity Safety Team will submit the end of year declaration and send via email ahead of 12 noon.

Appendix 1: End of Year Compliance position report
Appendix 1.1: ULTH CNST MIS Y7 Board Declaration
Appendix 1.2: CNST MIS SA1 position report

Maternity

United Lincolnshire Teaching Hospitals NHS Trust

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)

End-of-Year compliance position report

Amy Garratt
Maternity Safety Lead Midwife
Version 1.1
30/01/2026

Caring and building a healthier future for all

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Executive summary

Compliance with CNST MIS requires full achievement of all elements within each of the ten-safety action. The Trust intends to submit its Board Declaration (appendix 1.1) at the opening of the portal on 26th February 2026, ahead of the final submission date of 3rd March 2026, declaring non-compliance with requirement one of Safety Action 1 and, as a result, will have to return of a submission of overall non-compliance for the MIS Year 7 scheme.

Following submission of the Board Declaration, NHS Resolutions will review the submission and accompanying action plan, including the case details, reasons for the delayed notification to MBRACE that has resulted in non-compliance with Safety Action 1, associated learning, and mitigations. In parallel, MBRRACE-UK will undertake verification against the required standards and will report its findings to NHSR for a joint review. Based on the strength of the Trust's action plan and learning, this process

may result in the Trust being deemed compliant, leading to an upgrade to full compliance. If non-compliance is returned, the Trust will have an opportunity to submit a revised action plan for further consideration by MBRRACE-UK. Should non-compliance be upheld following the second submission, NHSR will support the Trust to apply for discretionary funding, acknowledging that the Trust will not be eligible for the full 10% incentive payment which, in previous years, has amounted to between £600,000 and £800,000.

This report and its accompanying appendices set out the Trust's position against all MIS Year 7 requirements. It is presented for review at the Group Quality Committee with request for approval of the intended submission of non-compliance ahead of Executive sign-off and submission of the Board Declaration. Key components including overview of standards, keys risks for Year 7 and the evidence summary have been hyperlinked for ease of reference and strengthened oversight.

Introduction

Following receipt of confirmation of full compliance with Year 6 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), United Lincolnshire Teaching Hospitals (ULTH) Maternity and Neonatal services are now in the process of preparing for submission for Year 7 of the scheme. NHS Resolution (NHSR) launched Year 7 MIS on April 2nd, 2025. The completed Board Declaration form must be submitted by 12 noon on 3rd March 2026 with the reporting period ending on 30th November 2025. Although the reporting period for Year 8 of the Maternity Incentive Scheme (MIS) commenced on 1st December 2025, the formal Year 8 standards are not expected to be published until April 2026. Until the official standards are released and any changes are confirmed, the Trust will continue to monitor, report and provide assurance against the Year 7 MIS requirements to ensure continuity, readiness, and sustained compliance.

Background

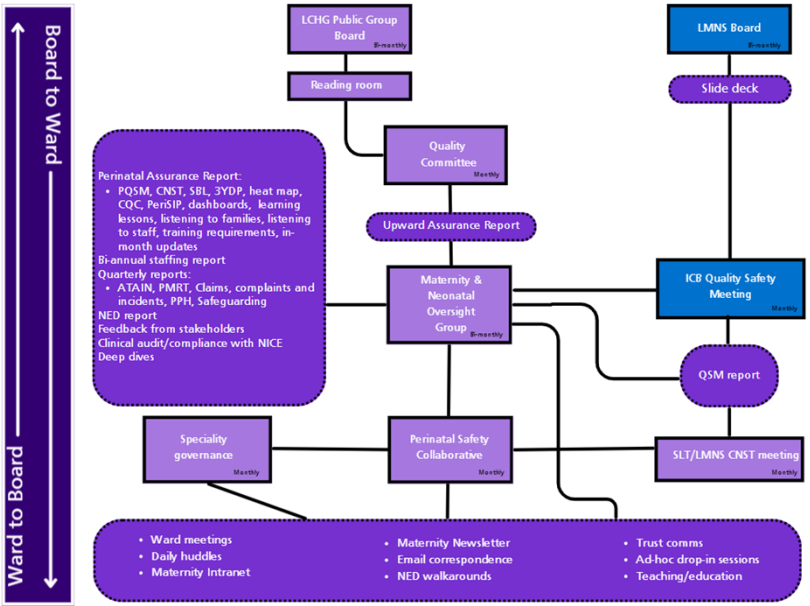
Now in its seventh year of operation, NHSR MIS continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST maternity incentive fund and they will also receive a share of any unallocated funds. In previous years this has amounted to between £600,000 to £800,000.

Purpose

This report provides a consistent and transparent overview of maternity service performance against the Year 7 MIS. This report supports ongoing assurance, early identification of risks, and proactive quality improvement by presenting up-to-date information, progress against required actions, and areas requiring escalation. It enables the maternity leadership team, divisional management, and trust-level assurance and oversight committees to monitor compliance, strengthen safety processes, maintain readiness for CNST assessment throughout the year and potential risks to compliance moving into Year 8 of the scheme.

Reporting and monitoring

Progress with the MIS is monitored via the Obstetric Governance, Maternity and Neonatal Safety Collaborative (MNSC) and the Maternity and Neonatal Oversight Group (MNOG). MNOG is chaired by the Group Chief nursing Officer who is the Executive sponsor and Trust Board Maternity safety Champion. The Non-Executive Director Board Maternity safety Champion also attends this meeting. MNOG in turn reports directly into Group Quality Committee (GQC), which is a subcommittee of the Board. GQC provides Trust Board with output following their review and discussion and therefore has delegated responsibility for maternity oversight. Trust Boards have a broad scope responsibility, covering all aspects of the Trusts governance, strategy and finance. They provide strategic direction and oversight while sub-committees such as GQC takes a more hands-on role in monitoring quality and safety performance. Both MNOG and GQC's in-depth examination of data, reports and practices provides the Board with a clear understanding of the Trusts performance on quality and safety including any immediate priorities and expectations.



Key dates and actions:

Date	Update	Action/progress
February 2025	NHSR released 'What to expect- an overview of changes' document	Benchmarked and actions ongoing
2nd April 2025	NHSR published Year 7 CNST MIS	Agreed process commenced including benchmarking of requirements, monitoring via the PeriSIP, monthly CNST update reports, bi-monthly upward reporting via MNOG, GQC and Trust Board and regular updates to the LMNS/ICB
28th April 2025	CNST MIS Year 7 Online launch webinar	Attended by relevant safety action leads, LMNS Lead Midwife and Corporate Compliance Team. No additional/further information gained
30th November 2025	End of Year 7 reporting period	
1st December 2025	Year 8 reporting period commenced	
21st & 27th January 2026	LMNS evidence review	Satisfied with evidence review and in agreement with final position
26th February 2026	Submission portal opens	

3rd March 2026	Submission deadline	
23rd March 2026	Expected return of provisional results	
April 2026	Expected release of Year 8 CNST MIS	

Overview of actions

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	6	1	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	5	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	13	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	4	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	20	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

CNST MIS Year 7 key risks

Although CNST provides an agreed standard with clear declarations of compliance or non-compliance, some requirements remain areas of concern for the service even when marked as compliant. It's important to retain this distinction. MIS compliance provides assurance against the national standard, but it does not mean all underlying issues are fully resolved and still present potential risk for ongoing service provision.

Safety action	Summary of risk	Update
SA 1 PMRT	**Return of submission of non-compliance** During routine evidence review, the Trust identified one eligible perinatal death that was appropriately managed and reviewed through local processes but was not notified to MBRRACE-UK within the required seven working days. This late submission represents non-compliance with Safety Action 1, as Standard A was not met, although Standards B, C and D were achieved. As compliance requires full achievement of all elements of the safety action, the Trust is therefore required to declare non-compliance with Safety Action 1 and, as a result, is unable to submit an overall compliant return for the MIS Year 7 scheme.	• The review of this incident has confirmed that the Trust maintains a historically strong and reliable process for notifying eligible perinatal deaths to MBRRACE-UK in line with CNST requirements, with 96% consistent track record of submitting notifications within 0–4 working days. The delayed notification identified during this reporting period has highlighted a need for strengthened processes to ensure this does not occur again. Importantly, the case was correctly recognised as not eligible for a full PMRT review, and therefore no delay in learning, parent engagement, or clinical governance processes occurred. However, as timely MBRRACE-UK notification is a mandatory element of the safety action, the Trust will return a submission of non-compliance, and this oversight highlights the need to strengthen verification mechanisms within existing pathways. The Trust have already commenced taking action to embed strengthened processes. • The Trust has responded promptly and constructively, with actions already under review to mitigate the risk of recurrence. These actions demonstrate a commitment to transparency, accountability, and continuous improvement. With these measures in place, the Trust is well-positioned to maintain robust compliance with safety action one going into Year 8 of the MIS, ensuring accurate national reporting, strong local governance, and ongoing assurance of safe, high-quality maternity care. • Further detail can be found within the SA1 compliance position report (appendix 1.2)
SA4 Clinical workforce	**Return of submission of compliance** The Trust have not met requirement 4.14 within safety action 4, however the requirements for an action plan with mitigations (5.15-5.18) and all other requirements within the standard have been met, therefore compliance can be submitted for this action.	• As previously reported within Year 6 MIS the neonatal unit does not meet the BAPM national standards for neonatal nursing staffing • The previously agreed action plan, including updates on progress and mitigations, is available in the QIS report • The QIS report is regularly shared via MNOG reporting routes bi-monthly and through LMNS board reporting routes with EMNODN oversight • This risk is also monitored via the risk register

Safety action	Summary of risk	Update
SA5 Midwifery workforce	**Return of submission of compliance** The Trust have not met requirement 5.4 within safety action 5, however the requirements for an action plan with mitigations (5.5 & 5.6) and all other requirements within the standard have been met, therefore compliance can be submitted for this action.	• BR+ establishment uplift business case approved by CRIG on 29th July to support recruitment into the 12.1wte deficit • Declined at ICB weighted values Framework on the 15th of September with a request for further evidence • Declined following second attempt at ICB values Framework on the 22nd of October with a request for further evidence • Declined following second attempt at ICB values Framework on the 17th of November • Following ongoing escalation via MNOG and GQC, the Trust has committed 450k to recruit 5.75 wte B6 midwives at a cost pressure whilst decision is taken. • The Trust committed to continue cost pressure and review on 1/4/26 and consider further cost pressure to ensure full recruitment into the 12.1wte deficit. • Action plan with mitigations against short-fall is reported via the bi-annual staffing report and bi-monthly updates at MNOG and regular updates via outward reporting routes to the LMNS/ICB. • Outside of the CNST MIS reporting period progress with this action will be monitored via MNOG and upward reporting route and the risk register. • Anticipated at risk action for Year 8 MIS.
SA7 MNVP	**Return of submission of compliance** The service, in collaboration with the LMNS, have concluded that the current MNVP lead contracted hours, compounded by reduced ICB/LMNS capacity to support is no longer sufficient to meet the year 7 requirement. Therefore, the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS for this safety action.	• At the outset of Year 7 the current MNVP lead hours and reduced LMNS/ICB capacity were insufficient to meet MIS requirements. This has been compounded as there is no MNVP lead in post within the LMNS, creating ongoing risk for CNST Year 8. • The Trust, LMNS and ICB have confirmed that Year 7 requirements cannot be fulfilled within existing MNVP resource; this position has been escalated via the PQOM to MNOG and the agreed Trust reporting routes to Quality Committee and Trust Board. This has also been escalated to LMNS Board. • Additional system funding (£38k) has been secured, but decisions on deployment, including potential outsourcing and future MNVP leadership, are still in progress. • Interim mitigations continue, including a co-produced action plan, benchmarking of the MNVP work plan, strengthened escalation pathways, exploration of Healthwatch and collaboration with regional MNVP leads to support gathering women's and families' feedback. • Delays in release of CQC maternity survey free-text and the absence of a confirmed MNVP lead continue to present risk.

Evidence summary

Safety Action One: PMRT

Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Requirement number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	No	PMRT case list: • generated from the PMRT tool • 97% compliance for standard A- 1 case notified 3 days after deadline • demonstrates compliance for all babies whose deaths were reviewed using the Perinatal Mortality Review Tool (PMRT during the CNST reporting period
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes	
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes	
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes	
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes	

6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes	Evidence is available to demonstrate that quarterly PMRT reports have been submitted for Q3, Q4, Q1, and Q2. These submissions include: • Individual case summaries for all applicable PMRT-eligible cases • Summary learning and action logs, outlining themes, learning points, and resulting improvement actions These reports form a standing agenda item at the Maternity and Neonatal Oversight Group (MNOG), where they are reviewed and discussed as part of routine governance. Following MNOG scrutiny, the reports are escalated upward via the Governance and Quality Committee (GQC) to ensure Board-level oversight and assurance. Full details of each quarterly PMRT report are made available to the Trust Board via the secure Reading Room, ensuring open access for Board members. In addition, a redacted, non-identifiable version of the report is shared at public Trust Board meetings to maintain transparency while protecting patient confidentiality. Accompanying evidence includes: • MNOG agenda papers and minutes • Upward reports to GQC • Confirmation of report availability within the Reading Room • Trust Board minutes demonstrating receipt of the redacted quarterly PMRT report
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes	

Safety Action two: MSDS

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes	Available evidence: • Screenshot of the FINAL BI Dashboard • Live Dashboard Power BI Link • PDF copy of the FINAL BI Dashboard
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes	

Safety Action three: TC/ATAIN

Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes	**Local Policies, Guidelines & Pathways:** • Neonatal Transitional Care Guideline • SA3 Position Paper-

			• The Home Visiting Programme of Neonatal Outreach Guideline • V1.1 Perinatal Safety Improvement Plan – TC actions extract • ULTH BAPM TC Framework Benchmarking 2025 • BAPM TC Framework for Practice Benchmarking Summary • HRG 2016 Levels Report **Workforce evidence:** • Band 7 Ward Manager Job Description • Band 6 TC Support Job Description • Lincoln Neonatal Workforce Tools • Boston Neonatal Workforce Tools **Ongoing data, monitoring and assurance:** • TC data collection (under review) • MNOG agenda papers and minutes • Upward reports to GQC • Quality & Safety Meeting Minutes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A	While the Trust can demonstrate compliance with the minimum evidence requirements for CNST MIS in relation to NTC, recent findings and discussions with the ODN have highlighted areas for further improvement. As a result, additional actions are in development to be added onto the Perinatal Safety Improvement Plan (PeriSIP). These actions relate to:

			• Guideline rewrite including admission criteria • Reporting of TC services • Workforce structure • Environment
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.			
For units commencing a new QI project			
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	N/A	
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	N/A	
Or **For units continuing a QI project from the previous year**			
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period and present an update to the LMNS and Safety Champions.	Yes	Evidence is available within the quarterly ATAIN reports for Q3, Q4 and Q1 with accompanying MNOG and GQC agendas, papers and minutes. Reporting to the LMNS via QSM and LMNS Board with accompanying agendas, papers and minutes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes	

Safety Action four: Clinical Workforce

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
a) Obstetric medical workforce			
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A	No short-term locums during the audit period
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes	• Compliance with RCOG expectations on pre-employment checks, induction, supervision, assessment of competency, and monitoring effectiveness evidenced via locally agreed checklist

			• Documented evidence via audit across a continuous six-month period within Feb 2025–30 Nov 2025. • Completed checklists for the eight locums employed during the audit period
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes	• Not reportable during Year 7 • Action plan available
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes	• Consultant Attendance Audit – Feb–Apr 2025 demonstrating compliance of 90% • Consultant Attendance Audit Presentation – Feb–Apr 2025 demonstrating learning and key findings • Clinical Escalation in Obstetrics and Gynaecology Guideline
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes	• MNOG, GQC and Trust Board agendas, papers and minutes.
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes	
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes	• Reporting to the LMNS via QSM and LMNS Board with accompanying agendas, papers and minutes
b) Anaesthetic medical workforce			
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of	Yes	• LCH rotas- representative month • PHB rotas- representative month

	communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.		• ACSA Standards and ULTH Accreditation letter • Local SOP for Consultant Anaesthetist Supervision
c) Neonatal medical workforce			
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes	• Overview paper demonstrating compliance with BAPM standards
10	Is this formally recorded in Trust Board minutes?	Yes	• MNOG, GQC and Trust Board agendas, papers and minutes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A	
12	Was the above action plan shared with the LMNS?	N/A	
13	Was the above action plan shared with the Neonatal ODN?	N/A	
d) Neonatal nursing workforce			

14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No	• Neonatal Workforce Tools
			  ○ LCH/PHB Q4, Q1 and Q2
			  ○ Regular agenda item at MNOG
			• Regularly reported with progress updates via the Perinatal Assurance Reports at MNOG
			• Additional QIS reports shared via MNOG

15	Is this formally recorded in Trust Board minutes?	Yes	• MNOG, GQC and Trust Board agendas, papers and minutes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes	• Risk Register entry/assessment

17	Was the above action plan shared with the LMNS?	Yes	• Reporting to the LMNS via QSM and LMNS Board with accompanying agendas, papers and minutes
18	Was the above action plan shared with the Neonatal ODN?	Yes	• Previously shared during Year 6 with progress updates provided at QSM and ODN meetings

Safety Action five: Midwifery Workforce

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes	• Bi-annual staffing Report -May with detail regarding the review conducted in March 2024

2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes	• Bi-annual staffing reports (November 2024 and May 2025)

3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: • Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes	• Bi-annual staffing reports (November 2024 and May 2025)
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	No	Available evidence demonstrates that: • The Trust identified a shortfall in funded establishment • A formal plan was developed to address the gap • Timescales and mitigations were agreed and minuted

5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	Yes	• The plan was shared through all agreed reporting routes up to the Trust Board ○ Bi-annual staffing reports (November 2024 and May 2025) ○ Perinatal Assurance reports demonstrating bi-monthly updates ○ MNOG agendas and minutes ○ Upward reports from MNOG to GQC and Trust Board including minutes ○ On risk register
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	Yes	• Reporting to the LMNS via QSM and LMNS Board with accompanying agendas, papers and minutes
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes	• Bi-annual staffing reports (November 2024 and May 2025)
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A	

9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes	• Bi-annual staffing reports (November 2024 and May 2025)
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A	

Safety Action six: Saving Babies Lives

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	No	• Not yet fully implemented
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	Yes	• Each Touch Point confirms progress against the four SBL elements as agreed with the ICB, with updates shared through MNOG and included within Perinatal Assurance Reports • MNOG, GQC and Trust Board agendas, papers and minutes

3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes	As per requirement one
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes	
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	Yes	

Safety Action seven: Listening to women

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes	• V2.3 Co-Produced Patient Experience Improvement Plan • MNVP Lead and SLT Monthly Meeting Terms of Reference • Q3, Q4 and Q1 Maternity Patient Experience Report • Interim Patient Experience Update Report – November 2025
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes	• Perinatal Assurance reports bi-monthly via MNOG, upwardly reported to GQC • Meeting minutes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes	• ULHT QSM Report • LMNS Board Presentation
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support	No	

	• Local service user volunteer expenses policy including out of pocket expenses and childcare cost		
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes	• MNVP Risk Report V1.6 • MNVP Mitigation Action Plan V1.2 • Perinatal Quality Oversight Model V1.0 • Perinatal Assurance reports bi-monthly via MNOG, upwardly reported to GQC • Meeting minutes • Trust Board papers and minutes • ULHT QSM Reports • LMNS Board Presentation
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting	N/A	

	• Patient safety meeting • Guideline committee		
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A	

Safety Action eight: Training

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12-month period using a training certificate or correspondence from the previous maternity unit.			
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
1	90% of Obstetric consultants?	Yes	• Training compliance November 2025 • Training weeks database November 2025
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes	
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A	
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes	
	Maternity emergencies and multiprofessional training		
5	90% of obstetric consultants?	Yes	• Training compliance November 2025 • Training weeks database November 2025
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,	Yes	

	foundation year doctors and GP trainees contributing to the obstetric rota?		
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A	
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes	
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes	
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes	
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes	
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes	
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes	• Drills Database Dec 2025 • Ward Based Drill Form

	Neonatal resuscitation training		
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes	• NNU NLS Trajectory 2025
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes	
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes	
17	90% of neonatal nurses? (Band 5 and above)	Yes	
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes	
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes	
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes	• Training compliance November 2025 • Training weeks database November 2025
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes	• NNU NLS Trajectory 2025

Safety Action nine: Floor to Board

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes	• Perinatal Quality Oversight Model V1.0 shared via MNOG, upwardly reported to GQC and via QSM to LMNS Board
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes	• Perinatal Quality Oversight Model V1.0 • MNOG minutes demonstrating attendance • Evidence in Trust Board Minutes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes	• Perinatal Quality Oversight Model V1.0 • MNOG papers
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes	• Perinatal Quality Oversight Model V1.0 • MNOG papers
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes	• Perinatal Quality Oversight Model V1.0 • MNOG papers

6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes	• Meeting attendance • Perinatal Assurance reports and MNOG minutes • GQC reports and minutes • NED reports
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April – 30 November)?	Yes	• Claims, Complaints and Incidents Scorecard Q3, Q4, Q1 & Q2 • MNOG papers and minutes • GQC reports and minutes • Trust Board papers and minutes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes	• Meeting attendance • Perinatal Assurance reports and MNOG minutes • GQC reports and minutes • Trust Board papers and minutes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes	• Perinatal Assurance reports and MNOG minutes • GQC reports and minutes • Trust Board papers and minutes • ULTH PCLP Case Study on Staff Experience Improvement Plan

Safety Action ten: MNSI/EN

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence summary
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes	• SA10 Summary document
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes	
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes	
4	For any occasions where it has not been possible to provide a format that is accessible for eligible families, has a SMART plan been developed to address this for the future?	Yes	
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes	
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes	
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes	• Perinatal Assurance Reports with bi-monthly updates • MNOG minutes • GQC Upward reports and minutes

8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes	• Trust Board papers and minutes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored and externally validated.	Yes	• SA10 Summary document

CNST MIS Year 8 key risks

All potential risks associated with the MIS safety actions as the service enters Year 8 will be incorporated into the Perinatal Safety Improvement Plan to ensure robust oversight and ongoing monitoring. These risks will be systematically reviewed and reassessed upon publication of the final Year 8 requirements, ensuring that identified mitigations remain appropriate and aligned with updated national expectations.

Safety Action	Anticipated risk	Risk overview
SA1: PMRT	Moderate	• Learning and actions from year 7 to remain on PeriSIP until embedded
SA2: MSDS	Minimal	
SA3: TC/ATAIN	Major	• Compliance will rely on Year 7 actions being completed in agreed timeframes with ODN oversight
SA4: Clinical workforce	Major	• Locum checklists require strengthened process • Workforce gaps may affect compensatory rest action plan and trajectories • Badgernet is unable to provide data required for consultant attendance audit • QIS risk ongoing
SA5: Midwifery workforce	Major	• Risk ongoing from year 7
SA6: SBLv3.1	Minimal	• Monitored via SBL risks on PeriSIP
SA7: MNVP	Major	• Risk ongoing from year 7
SA8: Training	Major	• Monitored via PeriSIP
SA9: Floor to Board	Minimal	
SA10: MNSI	Minimal	

Appendices

Appendix 1.1: Board Declaration
Appendix 1.2: CNST MIS SA1 Compliance Report

NHS Resolution

Maternity incentive scheme - Year 7 Guidance

Trust Name	**United Lincolnshire Teaching Hospitals NHS Trust**
Trust Code	**T565**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are ‘for and on behalf of’ the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.

Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Maternity

United Lincolnshire Teaching Hospitals NHS Trust

Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 7

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Amy Garratt
Maternity Safety Lead Midwife
V1.3
27/01/2026

Executive summary

This report outlines the Trust's position in relation to Safety Action 1 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) for the period 1 December 2024 to 30 November 2025. A requirement within the MIS (1.1) requires Trusts to demonstrate the timely use of the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK) notification system for all eligible perinatal deaths, with national standards mandating notification within seven working days.

During the routine evidence review, the Trust identified one eligible perinatal death that was appropriately managed and reviewed through local processes but was not notified to MBRRACE-UK within the required seven working days. This late submission represents non-compliance with Safety Action 1, as Standard A was not met, although Standards B, C and D were achieved. As compliance requires full achievement of all elements of the safety action, the Trust is therefore required to declare non-compliance with Safety Action 1 and, as a result, is unable to submit an overall compliant return for the MIS Year 7 scheme.

Background

The CNST MIS is a national programme established by NHS Resolution (NHSR) to improve the safety and quality of maternity services across NHS Trusts in England. The scheme provides a financial incentive for Trusts that can evidence compliance with ten core safety actions designed to reduce avoidable harm and strengthen systems of governance and learning. Within the requirements of safety action 1, Trusts must complete two distinct but interrelated processes when a perinatal death occurs. Although both processes relate to the same clinical event, they serve different purposes, operate on different timelines, and have different evidential functions within the MIS.

1. Notification of the death to MBRRACE-UK
    - MBRRACE-UK is the national surveillance system for perinatal mortality. Trusts are required to notify all eligible perinatal deaths to MBRRACE-UK within seven working days of the death occurring.
    - Deaths eligible for reporting to MBRRACE-UK and inclusion in surveillance are:
        - **Late fetal losses** – the baby is born at 22 or 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred
        - **Stillbirths** – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
        - **Neonatal deaths** – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.
    - NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 3 February 2026.

2. Completion of a full review using the National Perinatal Mortality Review Tool (PMRT)
    - The PMRT is a comprehensive, structured review process designed to examine the care received by babies who died in pregnancy from 22 weeks' gestation onwards or died within 28 days of being born (perinatal deaths).
    - It is undertaken by a multidisciplinary team and incorporates parents' views as a core component.

Situation

During the MIS Year 7 reporting period, the Trust, through its evidence review in preparation for submission, has identified one perinatal death that occurred in October that was eligible for MBRRACE-UK notification but not eligible for a full PMRT review. The death was eligible only for notification under the criteria of neonatal death, with the baby having been born at 20+3 with signs of life and sadly having died shortly after birth. The notification to MBRRACE-UK was submitted at ten working days following the death of the baby and not within the required timeframe of seven working days.

On identification of the delay in notification the maternity team have taken the following immediate actions:

1. Immediate escalation of the incident and associated findings to the Trust Safety Champions, Director and Head of Midwifery, Group Chief Nurse, and Clinical Lead accompanied by an early learning summary to support organisational oversight and assurance. This will also be shared with the LMNS.
    - *ULTH escalation completed 26/01/2026*

- *Outstanding action- escalation to LMNS and regional team*

2. A comprehensive review of all perinatal deaths within the reporting period has been completed, with cases triangulated against digital maternity records, the bereavement database, and the PMRT case list to ensure no additional cases were missed or notified late. None were identified that were applicable to CNST, using CNST inclusion criteria.
   - *Action completed 26/01/2026*

3. Review of all MBRRACE-UK notification-eligible cases and PMRT cases within the MIS reporting period to ensure that external verification will not identify any additional omissions or discrepancies. None were identified that were applicable to CNST, using CNST inclusion criteria.
   - *Action completed 26/01/2026*

4. The Trust has shared its position with NHSR and received confirmation of the agreed next steps, ensuring transparency, external assurance, and alignment with national reporting requirements.
   - *Action completed 22/01/2026*

Following completion of immediate action two, the Trust identified an additional case. This case does not fall within CNST reporting scope, as the baby died in a non-clinical setting. The mother booked late for antenatal care and, following diagnosis of fetal abnormalities, elected for termination of pregnancy with feticide at another care provider (Leicester). She returned home as planned and subsequently gave birth at home, with no signs of life. The case was notified to MBRRACE-UK at 14 working days. Whilst this is not reportable under CNST criteria, and therefore the CNST timescale of 7-days for notification does not apply, the Trust wanted to reference this case here for transparency.

Analysis

The Trust had an established and historically reliable process for notifying all eligible perinatal deaths to MBRRACE-UK, with 96% of notifications routinely completed by the bereavement team within 0–4 working days of the event. The remaining 4% was the one case within scope that was notified three days after the CNST timescale of 7-days. This process has consistently functioned well, with no previously missed or delayed notifications identified in earlier MIS reporting periods. The pathway includes prompt identification of eligible cases, clear delineation of staff responsibilities, and timely submission via the MBRRACE-UK portal. In the case under review, and in the one case that falls outside CNST scope, the delayed notification appears to be attributable to a systems gap rather than any misunderstanding of eligibility criteria, resulting in the case being inadvertently overlooked from a notification perspective. The family received the expected standard of care, and there is no evidence to suggest wider systemic or process failures. The Trust's overall compliance history

demonstrates robust adherence to the requirements of Safety Action 1. However, these incidents highlight the need to strengthen failsafe mechanisms within the notification workflow to further reduce the risk of recurrence, notwithstanding the historically strong performance of the process.

The impact of this oversight has been reviewed by the multidisciplinary team and can be reviewed below:

Impact	Detail
CNST MIS compliance	• Although the case in question was correctly identified as not requiring a PMRT review, the late notification constitutes a deviation from the expected reporting standard. • As a result, the Trust cannot demonstrate 100% compliance with the notification element for this case within the MIS period and will therefore return a submission on non-compliance with the accompanying financial and reputational impact. • The Trust has however demonstrated robust processes in place, as evidenced from previous years MIS programmes. The Trust will seek NHSR assistance in determining if compliance with the 96% of cases this year, and full compliance in previous years can be used to support a declaration of compliance following an evidence review.
National surveillance and data quality	• Timely MBRRACE-UK notifications ensure that national mortality surveillance remains accurate, up to date, and reflective of real-time patterns in perinatal outcomes. • The delay in this instance did not compromise the integrity of the clinical information submitted; however, any delay reduces the immediacy with which the case is included in national datasets and could, if repeated, undermine the reliability of national surveillance systems over time. • Whilst no harm has been identified, the Trust have identified learning opportunities and have already strengthened its processes and controls.
Local clinical governance and learning	• Because the case did not meet criteria for PMRT review, no delay occurred in conducting a clinical review or extracting learning at a local level. • Internal governance processes remained unaffected, and the absence of a PMRT review requirement means no interruption occurred to the Trust's learning, action planning, or parent-facing communication relating to care. • The case was reviewed in line with routine incident pathways.
Reputational and Regulatory Assurance	• While the incident represents a single, isolated oversight within an otherwise robust reporting pathway, the Trust recognises that any deviation from mandatory reporting timelines may raise concerns regarding governance reliability. • Transparent reporting of the error to Maternity and Neonatal Safety Champions, Trust Board, NHSR and the LMNS, alongside clear evidence of strengthened processes mitigates reputational risk and reassures

	regulators and system partners of the Trust's commitment to maintaining high standards of maternity data quality and safety oversight, in line with NHSR expectations for annual MIS compliance.
Impact on the family	• There was no impact on the family arising from the delay in notification. • The purpose of MBRRACE-UK notification is national data surveillance rather than clinical review, and the case was not eligible for PMRT. • Family engagement, care, and communication pathways therefore remained unaffected.

Mitigations and actions

The review of this incident has highlighted that while the Trust's MBRRACE-UK notification process has historically been robust, with notifications consistently submitted within 0–4 working days, the system remains vulnerable to isolated human error. This incident demonstrates that even well-established workflows can be impacted by momentary oversight, particularly in cases that fall outside the routine pattern of events (e.g., cases eligible for MBRRACE notification but *not* for PMRT review).

In response to the incident and the learning identified, the Trust will agree targeted actions to prevent recurrence and to provide assurance. Once agreed, the actions will be added onto the Perinatal Safety Improvement Plan (PeriSIP) for ongoing monitoring and oversight. Actions will focus on:

1. Strengthening notification safety checks
    - Introduce a secondary verification step whereby all eligible perinatal deaths are cross-checked by a second member of staff within an agreed timeframe.
    - Implement a weekly review utilising BadgerNet to generate a list of all perinatal deaths recorded within the system during the preceding week.
        - The report will be reviewed by a designated member of the bereavement or maternity governance team to cross-reference all cases against MBRRACE-UK notification requirements, ensuring that any eligible deaths are identified promptly.
        - Any discrepancies—such as cases logged in BadgerNet but not yet notified—will trigger an immediate review and completion of the notification process.

2. Review of local guidance/SOP to set out the process for identifying and notifying all eligible perinatal deaths ensuring failsafe mechanisms are explicitly outlined.

3. Ongoing monitoring and governance oversight

- Include MBRRACE-UK notification timeliness as a standing item for review within the Learning Lessons section within the Perinatal Assurance report presented bi-monthly at the Maternity and Neonatal Oversight Group.

Process for return of submission of non-compliance

The Trust intends to submit its Board Declaration at the opening of the portal on 26th February 2026, ahead of the final submission date of 3rd March 2026, declaring non-compliance with requirement one of Safety Action 1. NHSR will review the submission and accompanying action plan, including the case details, reasons for the delayed notification, associated learning, and mitigations. Early submission provides NHS Resolution with the opportunity to request further information or amendments while the portal remains open. In parallel, MBRRACE-UK will undertake verification against the required standards and will report its findings to NHS Resolution for a joint review. Based on the strength of the Trust's action plan and learning, this process may result in the Trust being deemed compliant, leading to an upgrade to full compliance. If non-compliance is returned, the Trust will have an opportunity to submit a revised action plan for further consideration by MBRRACE-UK. Should non-compliance be upheld following the second submission, NHS Resolution will support the Trust to apply for discretionary funding, acknowledging that the Trust will not be eligible for the full 10% incentive payment which, in previous years, has amounted to between £600,000 and £800,000

Conclusion

The review of this incident has confirmed that the Trust maintains a historically strong and reliable process for notifying eligible perinatal deaths to MBRRACE-UK in line with CNST requirements, with 96% consistent track record of submitting notifications within 0–4 working days. The delayed notification identified during this reporting period has highlighted a need for strengthened processes to ensure this does not occur again. Importantly, the case was correctly recognised as not eligible for a full PMRT review, and therefore no delay in learning, parent engagement, or clinical governance processes occurred. However, as timely MBRRACE-UK notification is a mandatory element of the safety action, the Trust will return a submission of non-compliance, and this oversight highlights the need to strengthen verification mechanisms within existing pathways. The Trust have already commenced taking action to embed strengthened processes.

The Trust has responded promptly and constructively, with actions already under review to mitigate the risk of recurrence. These actions demonstrate a commitment to transparency, accountability, and continuous improvement. With these measures in place, the Trust is well-positioned to maintain robust compliance with safety action one going into Year 8 of the MIS, ensuring accurate national reporting, strong local governance, and ongoing assurance of safe, high-quality maternity care.

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

Minutes of the Joint Public Board Meeting

Held on 6 January 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
Mr Neil Herbert, Non-Executive Director
Professor Karen Dunderdale, Group Chief Executive
Mr Daren Fradgley, Group Chief Integration Officer
Mr Paul Antunes Goncalves, Group Chief Finance Officer
Mrs Nerea Odongo, Group Chief Nurse
Professor Colin Farquharson, Group Chief Medical Officer

Non-Voting Members:
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Ms Caroline Landon, Group Chief Operating Officer
Miss Claire Low, Group Chief People Officer
Mr Mike Parkhill, Group Estates and Facilities Officer
Mrs Jayne Warner, Group Director of Corporate Affairs
Mrs Sarah Buik, Associate Non-Executive Director
Mr 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)
Ms Gemma Hayselden, Ward Sister, Scampton Ward (Item 3.1)
Ms Julie Smith, Special School Team Manager (Item 3.2)

Apologies:
Ms Dani Cecchini, Non-Executive Director
Mr Ian Orrell, Associate Non-Executive Director

001/26	**Item 1 Introduction** The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.

002/26	**Item 3 Apologies for Absence** Apologies for absence were received from Ms Dani Cecchini, Non-Executive Director and Mr Ian Orrell, Associate Non-Executive Director.
003/26	**Item 3 Public Questions** **Question 1 – Mandy Watmore** Why are the in-house pharmacy incapable of supplying to your ophthalmic department an alternative to the antiseptic iodine eye wash prior to an eye injection? The product previously supplied was Chlorhexidine which had been continuously supplied for this purpose until end of July this year? I am at a loss as to why the new pharmacy contract is incapable of supplying the chlorohexidine necessary to allow my and other macular patients these eye injections. The complaints procedure also is in need of revision
004/26	The Group Chief Medical Officer responded that the unavailability of chlorhexidine was due to the Medicines and Healthcare Products Regulatory Agency (MHRA) suspending the manufacturing licence on 4th August 2025 and all remaining stock had to be withdrawn nationally from use, and the supply of an immediate alternative was not available.
005/26	The Group Chief Medical Officer offered that this product shortage had not been communicated to the organisation by the MHRA in the same way other shortages had, and therefore there had been a short delay in sourcing and ordering a replacement product. The situation had now been rectified, and stock was now readily available within the pharmacy.
006/26	The Group Chief Medical Officer explained that pharmacy processes had now been adapted to ensure that further shortages of medicines were captured and a specific Microsoft Teams chat function, which included specialist pharmacist and representatives from the Drugs and Therapeutics Committee, had been established to ensure that alternative medicines could be sourced, ensuring that the system was more robust moving forward.
007/26	**Q2 Received from Vi King** Please can I ask if barium meals are done at Grantham Hospital. I have been informed that some patients are being told they have to go to Lincoln. If this is correct, please can I ask the rationale as to why these are not being done at Grantham Hospital.
008/26	The Group Chief Operating Officer responded that the organisation did not have a fluoroscopy machine at Grantham Hospital, which was required to complete barium meals, and therefore this provision had never been offered at Grantham. It was explained that due to pathway changes, CT scanners were now used rather than barium enemas, therefore this equipment was not warranted on this site. The Group

	Chief Operating Officer offered to have a further conversation with Mrs King regarding this, if required.
009/26	**Item 3.1 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.
010/26	Sister Hayselden Scampton Ward, Lincoln County Hospital was welcomed to the meeting to celebrate achievements.
011/26	The Group Chief Nurse explained that Scampton Ward 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.
012/26	Sister Hayselden shared some examples with Board members of achievements within Scampton Ward which specialised in dementia and Parkinson's disease and explained that a range of initiatives to improve patient experience had been introduced. Following feedback, a 'breaking bad news' room had been set up, a quiet space that staff were able to use to speak to patients and families about sensitive subjects or deliver bad news away from the busy ward environment.
013/26	Following relative feedback, the Ward had also purchased z-beds using charitable funds, so that carers or those whose relatives were nearing the end of life were able to stay overnight near to their loved ones.
014/26	The Group Chair thanked the Ward Sister for sharing these examples of good work and acknowledged the compassion and care that shone through in the presentation.
015/26	Mrs Brown commented on the leadership stability that the Ward Sister had offered to the team over the last three years and also reflected on the focus of being able to provide comfort to carers being exceptional. Mrs Brown expressed a view that the team should be proud of what had been achieved.
016/26	Mrs Wells agreed with Mrs Brown's comments and referred to a good culture of listening to the feedback provided and by taking action, making good use of charitable funds to purchase the z-beds. Mrs Wells thanked the team for the service being delivered.
017/26	The Group Chief Executive commented on the exceptional leadership being demonstrated by the Ward Sister and was pleased to hear of the action that had been taken following the feedback received. The Group Chair referred to one of the three values across the Group, collaboration, and expressed a view that had been demonstrated and that the team should be proud of all they had achieved.

018/26	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.
019/26	**Item 3.2 Patient/Staff Story** The Group Chief Nurse welcomed the Julie Smith, Specialist School Nurse from St Francis School in Lincoln, a special school that teaches 174 children with complex needs.
020/26	Board members were shown a video in which the Specialist School Nurse and School Headteacher described the work undertaken with the children attending the school, offering medication, therapies and urgent response to ensure they could continue to attend school and receive an education and also described how the team offered staff members training and support, in caring for children with complex medical needs, keeping them in school and preventing hospital admissions. The Specialist School Nurse offered that the multi-professional team consistently went above and beyond to ensure families received the support required, and Board members acknowledged the tremendous impact the team had on the school, the children and the families they supported.
021/26	The Group Chief Estates and Facilities Officer thanked the Specialist School Nurse for the services that were being provided to the children and added that it was clear that this was making a difference in ensuring that the children received a good education.
022/26	The Group Chair commented that this team had won the Chair's Award at the 2025 Staff Awards and offered that several letters had been received, supporting the nomination from parents making the point on the support that was provided.
023/26	The Group Chief Executive commented on the phenomenal work of the team and explained that she had previously visited the team and had been overwhelmed by the impact the services provided had on the children and their families and had felt that again by watching the recording shared. The Group Chief Executive expressed a view that this offered true care closer to home, moving care away from the acute hospital environment.
024/26	The Group Chief Executive asked how long it had taken the team from having an idea of what could be delivered to today, offering this exceptional service. The Specialist School Nurse responded that there was more work to do and that the numbers of children in school with complex needs had increased since the pandemic and a much improved MDT service was now offered, however there was still further room for improvement.
025/26	The Group Chair thanked the Specialist School Nurse for attending the meeting and for sharing the impressive work of the team. The Board: • **Received the Patient/Staff Story**

026/26 027/26	**Item 4 Declarations of Interest** There were no additional Declarations of Interest made. The Group Chair took this opportunity to welcome new Associate Non-Executive Directors Mr Paul Marsden and Mr John Underwood to their first Board meeting, and looked forward to working with them in the future.
028/26	**Item 5 Minutes of the meetings held on 4th November 2025** The minutes of the meeting held on Tuesday 4th November 2025 were approved as an accurate record.
029/26	**Item 5.1 Matters Arising from the previous meeting/log** The Board reviewed the action log, and the following updates were provided: 386/25 – The Group Chief Medical Officer commented that this action related to a cluster of MRSA infection prevention and control cases within maternity and had since been largely reported on via the Quality Committee upward report. He advised that the cases, at both Pilgrim Hospital Boston and Lincoln County Hospital had not been cross-infected cases and there had been no ongoing cluster incidents since. The Board agreed to close this action. 716//25 – A Board Development Session on Maternity Service was in the process of being arranged. The Board agreed to close this item. 728/25 – The Group Chief Medical Officer informed the Board that work was ongoing to align job planning for Consultants with Care Groups to make the best use of Doctor resource for productivity purposes. He added that there was strong compliance in this area with both Consultants and (Specialty and Specialist) SAS Doctors and the Group was considered nationally as exemplars in this arena. Work was underway for 2026/27 in terms of improving the job planning cycle and reporting would take place through both the People and Finance and Performance Committees. The Board agreed to close this item. The Board: • **Received the action log**
030/26 031/26	**Item 6 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 across the festive period and during the recent period of industrial action, where elective activity had been maintained, and took the opportunity to thank all staff members for all the work they had done. During October and November the 2026/27 Planning Guidance had been received, and work had been undertaken to submit a first draft of the Plan; the Group Chief

	Executive offered that the Group was on track to submit the next iteration in February 2026.
032/26	The Group Chief Executive advised that Sir Jim Mackey, NHS England Chief Executive and Jo Lenaghan, Chief Workforce Officer had written to all Trusts confirming NHS England were formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism and encouraged all NHS Organisations to adopt and note the associate commitments to free speech, to reinforce the collective stance against antisemitism. Lincolnshire Community and Hospitals NHS Group (LCHG) was committed to this ask and would continue with the planned local actions and ensure that the national actions were embedded when new guidance and training was released.
033/26	NHS England had also written to all NHS Trusts in December with requirements to strengthen processes to promote sexual safety and reduce sexual misconduct in the NHS which included several new actions to undertake. The Group Chief Executive explained that Trusts were required to review chaperoning policies to ensure that these reflected the key principles in the improving chaperoning guidance, along with establishing review groups to ensure that sexual misconduct reports were correctly and robustly considered. The Group had reinforced its commitment to creating a safe environment through the launch of the Sexual Safety Charter.
034/26	With regards to Group specific issues, the Group Chief Executive outlined that following an inspection carried out in September 2025 into end-of-life care at LCHS, the CQC published the report on 24th November 2025. The overall rating of the service remained as 'Good' which demonstrated continued commitment to providing high quality end of life care to the residents of Lincolnshire.
035/26	The Group had the privilege of hosting the Public Board meeting of the Health Services Safety Investigations Body (HSSIB) in November 2025, providing a valuable opportunity to observe the proceedings. Following the meeting, Group representatives engaged with HSSIB to showcase the significant patient safety improvements currently being implemented across the Group. Immediate feedback from HSSIB was positive, recognising the depth and quality of the patient safety work and noting the substantial impact these initiatives were expected to deliver once fully embedded.
036/26	During December 2025, the National Oversight Framework ratings for Quarter 2 had been published. For this period, ULTH remained in segment 4, ranking 124th out of 134 acute trusts. LCHS was placed in segment 4, ranking 46th out of a peer group of 61. The data highlighted several areas where services compared well against peers, and the publication of these metrics enabled teams to focus on opportunities for improvement to benefit patients. The Group Chief Executive explained that it was important to note that the report reflected performance from three months ago and whilst there remained more to do, several access measures had continued to improve since then.
037/26	The first Provider Oversight Group Meeting for the Group with the NHS England (NHSE) regional team took place during December 2025, chaired by the Director of System Co-ordination and Oversight. The meetings had been established in line with

	the oversight arrangements linked to the NHS Oversight Framework. The meeting was positive and there was recognition of the improving position across performance and finance.
038/26	The Group continued to face significant challenges due to the national rise in cases of flu and other respiratory illnesses. In response to this, NHSE issued guidance for all trusts to increase healthcare worker flu vaccine uptake further. Across the Group it had been agreed to aim to vaccinate at least 58% of acute staff and 55% of community staff this year. In addition, the Group had introduced mandatory mask wearing in all clinical areas providing patient care across the organisation, reflecting commitment to protecting patients and staff, reducing transmission risk, and maintaining resilience during a period of heightened seasonal pressure.
039/26	Following a successful pilot of the Pharmacy First initiative at Lincoln Urgent Treatment Centre (UTC), a new referral pathway would be rolled out across all UTCs and Clinical Assessment Services (CAS) in 2026.
040/26	The School Aged Immunisation Service (SAIS) for Lincolnshire had been recognised as one of the leading performers in the region, surpassing both Midlands and national averages. Since September 2025, the team had successfully administered over 51,500 flu vaccinations to children aged 4–16 across the county, helping to protect thousands of families and communities. LCHS would continue to host and deliver SAIS in Lincolnshire for a further 3 years.
041/26	The county's Community Diagnostic Centres (CDC) had celebrated winning Gold in the CDC of the Year category in the joint building project for the Lincoln and Skegness CDCs, which had been honoured at the Building Better Healthcare Awards 2025.
042/26	The Group Chief Executive also took the opportunity to inform Board members that Carol Jackson, Healthcare Support Worker at Lincoln County Hospital, had been honoured with the prestigious Chief Nursing Officer for England Award. She offered that Ms Jackson played a vital role in supporting patients undergoing cancer treatment, providing emotional care and compassion during what was often an incredibly challenging time. The national award recognised Ms Jackson's outstanding contribution and the meaningful difference made each day to the lives of both patients and nursing colleagues. The Board: • **Received the report and noted the significant assurance provided**
043/26	**Item 6.1 Group Model Workstream Progress Briefing** The Group Chief Executive presented the report which was taken as read and explained that this was a high-level briefing in respect of progress against Group developments and key milestones. On the whole focus remained on the slippage of some of the agreed timescales as previously reported, revised timescales had now been included in the plan and the Group Chief Executive remained confident on some of the supporting actions being undertaken.

044/26	The number of out of date policies within the acute element of the Group continued to be an area of strong focus and an improvement plan and trajectory was now in place with weekly Executive oversight.
045/26	The development of an Estates Strategy had commenced, and the Partnership Strategy was also being refreshed in line with the Group Strategy, due to a change in creating the Alliance Care Group within the operating strategy.
046/26	The Group Chair commented on the good progress being made and noted the issue of escalation in respect of policies. The Group Chair suggested reviewing the milestones within the next iteration of the report. **Action: Group Chief Executive, 3rd March 2026** The Board: • **Received the report and approved the ongoing developments** • **Noted the escalation and mitigations as described**
047/26	**Item 6.2 Winter Plan** The Group Chief Operating Officer presented the report which was taken as read and explained that available capacity was being utilised for Intravenous (IV) therapy and Outpatient Parenteral Antimicrobial Therapy (OPAT) work with pathways being flexed and an increase in daily monitoring.
048/26	Paediatrics at the front door was now operational and there was good progress being made at Lincoln County Hospital, with further work required at Pilgrim Hospital, Boston through Divisions; potentially with colleagues being utilised in alternative ways.
049/26	The Group Chief Operating Officer offered that resilience had been maintained over the festive period with no elective cancellations due to bed pressures.
050/26	The improvement in Urgent and Emergency Care performance continued, however challenges had been experienced in 12 hour discharges.
051/26	Mrs Brown acknowledged the excellent work that had been undertaken in this area, recognising that there was more to learn and commented that the teams should be proud of the work they were doing. It was acknowledged that the winter pressures had been coupled with periods of industrial action and being able to maintain patient safety was important.
052/26	The Group Chair agreed with Mrs Brown's comments and added that to maintain elective activity was a great testament to the planning that had been undertaken. Issues relating to discharges which were dependent on multi-disciplinary team response were also recognised. The Board: • **Received the report and noted the reasonable assurance provided**

	Item 8 Strategic Aim 1 Patients
053/26	**Item 8.1 Assurance and Risk Report Quality Committee** The Chair of the Quality Committee, Mr Connolly, presented the Committee reports following the meetings held during November and December 2025 with the reports taken as read with no formal escalations to be made. Mr Connolly drew the Board's attention to the December meeting focussing on the Board Assurance Framework and the ongoing and continued development of the performance dashboard.
054/26	Two formal escalations were made to the Board in respect of maternity services; the first relating to Clinical Negligence Scheme for Trusts (CNST) Standard seven, Maternity Voices, and Mr Connolly informed the Board that given the current hours and a reduction in support from Lincolnshire ICB and the Local Maternity and Neonatal System (LMNS), ULTH would not be in a position to meet the year seven standards for Maternity Voices. However, through the Maternity and Neonatal Oversight Group (MNOG) upward report the Committee was assured that work was continuing to mitigate this with a focus on co-production. Mr Connolly reiterated that this presented a significant risk to the achievement of the year seven standard.
055/26	The second escalation related to the maternity workforce and as previously highlighted the gap in workforce of 12.1 whole time equivalents (WTE). 5.75 WTE had been appointed into that gap at risk, however Mr Connolly informed the Board that the remaining posts were to be funded at a cost pressure. Mr Connolly advised that work was ongoing with the Lincolnshire ICB to rectify this situation.
056/26	Mr Connolly also offered the following updates on CNST Standards:
057/26	CNST Standard 1- PMRT – the upward report of Q2 was received and detailed the deaths reviewed from 1 December 2024, any themes identified and the consequent action plans. Reviews of deaths and consequent action plans were available to the Board in the reading room.
058/26	CNST Standard 3 – ATAIN an update was provided relating to the continuation of the Quality Improvement Project 'Midwives as second checkers for neonatal IV antibiotics' and the Trust position of compliance with the minimum evidence requirement for CNST MIS Year 7 for pathway of care for babies from 34+ weeks was noted by the Committee. In respect of Perinatal services it was acknowledged that there were areas requiring improvement including recommendations from the ODN Peer Review; these actions were monitored via the PeriSIP and agreed reporting routes.
059/26	CNST Standard 4- Clinical Workforce: Obstetric workforce the Trust had implemented RCOG guidance on engagement of both short-term and long-term locums and is compliant with criteria having been met for employment of locum doctors in Obstetrics and Gynaecology. This has been demonstrated through a 6-month audit. The Trust was 97% compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document. This had been demonstrated through a 3-month audit. Progress was also received on the previously agreed action plan to support working towards implementation of the RCOG guidance on Compensatory rest.

060/26	Neonatal workforce: The neonatal unit met the British Association of Perinatal Medicine (BAPM) national standards of medical staffing. It was recorded within Trust Board minutes progress against the previous Board agreed QIS action plan and trajectories and that this is on the services risk register.
061/26	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 has been confirmed by the ICB as demonstrated in the SBLCB implementation tool.
062/26	CNST Standard 9- Floor to Board: A non-executive director (NED) had been appointed and was visibly working with the Board safety champion (BSC). A review of maternity and neonatal quality and safety undertaken by the Board using a minimum data set as outlined in the PQSM bi-monthly and the Board Safety Champion met with the Perinatal leadership team and the Quad leadership team at a minimum of bi-monthly. Progress was also being made in respect of the Staff Experience Group (maternity and neonatal culture plan).
063/26	CNST Standard 10- MNSI: The Committee received Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution and evidence that families had received information on the role of MNSI and NHS Resolution's EN scheme in an accessible format in the patient's own language and the Committee must have sight of evidence of compliance with the statutory duty of candour.
064/26	Mr Connolly informed the Board that interim early findings had been released by Baroness Amos with initial benchmarking undertaken which would be discussed further at MatNeosip meeting and any actions adding to MatNeosip action plan as required.
065/26	As Maternity Safety Champion, Mrs Brown offered that alongside her fellow Board Safety champion, the Group Chief Nurse, and in collaboration with the MNVP lead and other ICB colleagues, ULTH met with the Perinatal Leadership team on a bi-monthly basis via MNOG to review progress and identify areas where support was required from the Quality Committee and the Board. Any such examples of support were escalated via the upward reporting arrangements to Board, where Mrs Brown and the Group Chief Nurse highlighted such areas of support and work to implement these with the support of fellow members of the Board.
066/26	Mr Connolly explained that the organisational C-difficile trajectory remained high and off target and action plans were in place to mitigate any risk. Mortality rates remained as expected, however the Committee had sought further assurance in relation to the impact of the waiting listing in ophthalmology.
067/26	Further assurance had also been requested relating to mixed sex accommodation and unjustified breaches; recognising that a task and finish group was in place. The Committee had also requested assurance around the governance and decision making moving forward.

068/26	The Committee also received the modern slavery annual statement, which was recommended to the Board for approval.
069/26	The Group Chief Nurse offered that in relation to maternity and the MNVP escalation to the Board, that this issue was being reviewed across the ICB Cluster and in the MNVP entry mitigations which were being added to ensure the women's voice was not being lost, including through the maternal and black maternal health group.
070/26	The Group Chief Nurse also offered that in relation to maternity staffing, there was assurance that the organisation was meeting one to one care in labour consistently by 90% - 100% and the triage model was being worked to and reported through to MNOG. There were less than 1% of red flags across maternity for both units.
071/26	Patient moves at night was a further area of concern and the Group Chief Nurse provided assurance that this was an area which required focussed work in partnership with the Group Chief Operating Officer, including strengthening processes during the day and limiting patient movement at night.
072/26	In respect of mortality, the Group Chief Medical officer offered that the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) had been within expected limits and stable for several years and had recently been demonstrating an improving position.
073/26	The Group Chief Finance Officer explained that the maternity cost pressure had been included within the modelling of the 2026/27 Annual Plan and active discussions were continuing with Commissioners.
074/26	Mrs Brown offered that there was potential for the MVP issues to be rectified, however each year this was becoming increasingly difficult to achieve and would be challenging.
075/26	The Group Chair acknowledged Mrs Brown's comments and the hard work that had been undertaken over the years to achieve the CNST standards and expressed a view that innovative and creative thinking may be required if the organisation was to continue to meet the standards. The Board: • **Received the assurance reports, and two formal escalations relating to maternity workforce and maternity voices** • **Noted the remaining updates on the CNST Standards as presented** • **Approved the Modern Day Slavery Statement**
076/26	**Item 8.2 Finance Briefing** The Group Chief Finance Officer offered a summary of performance at month eight, the year-to-date financial position for the Group was a £12.3m deficit, which was £2.4m adverse to plan. This was mainly due to the profiling of financial planning through the year, as well as additional financial pressures as a result of industrial action and required the Group to take action in the coming months to enable a return to financial balance by 31 March 2026.

077/26	The Group Chief Finance Officer advised that there were three key areas of internal focus to support the recovery of the financial position, which were being monitored with Care Groups and Corporate Leads; variable income delivery; delivery of cost improvement programme (CIP), which had delivered savings of £41.9m, however £0.7m lower than plan. Some schemes were not delivering as planned and further mitigations were being looked at to ensure delivery; workforce controls, including introducing medical spend caps, vacancy control process, rostering controls and delays to start dates.
078/26	With regards to capital expenditure £28.4m had been delivered in-year, which was £21.1m lower than planned and was mainly driven by delays in approval, however the Group Chief Finance Officer anticipated that this would be recovered by the end of the financial year and the Group Chief Estates and Facilities Officer assured Board members that this work was on schedule to deliver by the end of the financial year.
079/26	To address this, mitigating options had been reviewed, and the Finance and Performance Committee had been requested to support a proposal for a change to delegated authorities and for the approval of two out of four Executives to make changes, for example moving between financial years and to ensure that all the capital spend was utilised by the end of the financial year. In addition an increase was requested for the Group Chief Finance Officer approval limits of up to £2m, in order that actions could be expedited, all of which would retrospectively be taken through Committees and Board to ensure transparency, all in line with the strategic direction of travel.
080/26	The Group Chief Nurse offered an update on nursing spend explaining that as part of sickness management, an enhanced care protocol was being looked at to ensure that any nursing vacancies were all internal. Collaborative bank across the Group had also been launched to allow the spread of workforce and controls for approval of bank had been strengthened. Staff members owing the organisation hours had also been stopped from undertaking bank work. Rosters were in the process of being cleansed ensuring that hours were being used, prior to requesting temporary staffing. There was also a push on the working time directive, ensuring staff members took breaks which had also had an impact on temporary spend.
081/26	From a medical workforce perspective, the Group Chief Medical Officer advised that weekly meetings were taking place with care groups with increased scrutiny in terms of gaps. It was noted that benchmarking had been undertaken with other Trusts in respect of actions being taken against the use of temporary staffing. The Group Chief Medical Officer also offered that any gaps or high areas of temporary staffing were being fed into Committees, as well as the detail of any incidents. The Board: • **Received the report noting the reasonable assurance** • **Approved the changes in delegated authority as set out**

082/26	**Item 8.3 Assurance and Risk Report Finance and Performance Committee** Mrs Buik provided the assurances received by the Finance and Performance Committee, at the meetings held during November and December 2025; the reports were taken as read, noting that there were no escalations.
083/26	In relation to objective 1b, Mrs Buik advised that the Committee were now receiving upward reports from the Planned, Unplanned and Out of Hospital Groups.
084/26	Mrs Buik explained that the new Committee performance dashboard had strengthened assurance and was assisting to focus further discussions. Relating to the National Oversight Framework, data issues had affected rankings, the Committee was assured that these issues had now been fully resolved for ULTH, however for LCHS this remained an issue. Positive community performance was acknowledged by the Committee, specifically with regards to the Urgent Community Response target.
085/26	Virtual bed occupancy was above the national 80% target, and the Committee noted the achievement of zero 52 week waits within ULTH and assurance was provided relating to workstreams for cancer and 52 week waits; both areas were expected to demonstrate improvement from the November and December 2025 figures shortly. Challenges relating to the 12 hour wait position were also received by the Committee.
086/26	Mrs Buik explained that the Committee had received a full suite of finance papers in November and December 2025 providing assurance on the figures and robust processes in place to monitor and manage the financial performance where and a surplus had been delivered. Scrutiny remained on the cost improvement programme, with the Surgery Care Group significantly improving its position. Temporary medical workforce and the patient services hub were highlighted as two key risks. A detailed discussion had taken place on the approach to prioritising actions for year end. A change to the governance approach had been requested at the recent Committee meeting, which had been fully supported.
087/26	The Committee had also received the Finance Strategy with the Committee noting the intent to bring together the finance teams across the Group, ensuring work was aligned with the Group Strategy and Values.
088/26	Mrs Buik informed those present that the Carbon Energy project contract had now been signed.
089/26	Authorised Engineers audit reports had been received, which was positive and provided additional assurance for areas of the LCHS estate. Some areas of concern had been highlighted to the Committee relating to operational performance due to a significant number of estates jobs being realised though the helpdesk. However, planned preventative maintenance (PPM) was on target for completion in January 2026 which would provide some mitigation. The Committee was informed of some issues with lift maintenance, and an action plan was in place which would continue to be monitored.

090/26	An update was received on Martyn's Law, which would come into effect in April 2027, relating to lockdown procedures on Hospital sites however it was noted that there may be a requirement for additional funding to enable this to be achieved across the Group.
091/26	The 2024/25 Health and Safety Annual Report had been presented and was recommended to the Board for approval.
092/26	A proposal had been considered to reduce the very high risk held on the Board Assurance Framework recorded at 20, to high with a score of 16, based on the increased assurance which was now being received, and this was recommended to the Board.
093/26	Information Governance had been under increased demand, partly due to the number of projects and improvements and the Committee would continue to monitor as a potential risk.
094/26	Data Protection and Security Plans had been submitted to NHS England and were now approved. The Board: • **Received the assurance report** • **Approved the 2024/25 Health and Safety Annual Report**
095/26	**Item 8.4 2026/27 Draft Plan Submission** The Board received an update on the first draft 2026/27 national Planning Submission, which outlined how the Group would meet a range of expectations around activity, productivity, performance trajectories, finance and workforce, notwithstanding some of these areas would be challenging to deliver.
096/26	The Group Chief Integration Officer explained that further work was underway by Executives to identify future cost savings, workforce improvements and how transformation of services and 'left shift' of activity out of acute hospitals and into the community, as well as digitalisation, would support the delivery of the plan.
097/26	The Group Chair acknowledged the work being undertaken to reach a balanced position and recognised the financial deficit plan and the commitment to move to a balanced position. The final submission would be made in February 2026, and a plan would be developed for approval by the Board. The Board: • **Received the report and noted the assumptions**
	Item 9 Strategic Aim 2 People
098/26	**Item 9.1 Assurance and Risk Report People Committee** Mrs Wells provided the assurances received by the People Committee, at the meeting held during November and December 2025 and the report was taken as read.

099/26	A visit by colleagues from the University of Lincoln relating to medical education had been positive.
100/26	Assurance had been received by the Committee regarding medical and nursing safer staffing reports with the position remaining stable.
101/26	The “Be Kind” initiative had been launched and the Committee acknowledged that it was not always easy for staff to work within unfamiliar areas. “Be Kind” was intended to be helpful and supportive for staff to ensure they felt more comfortable regardless of the environment they were working in.
102/26	An update had been received on the Resident Doctor 10 Point Plan, with many of the actions applying to all staff across the Group.
103/26	A positive update had been received relating to significant OD interventions in the Emergency Department around culture and leadership within the team, where support would continue to be provided.
104/26	The sickness position had been recognised along with the appointment of a Sickness Manager who would be providing support to leaders to improve the position.
105/26	It was noted that the HR Directorate support to the change programmes was significant and there was a review in place to ensure all priorities were being met.
106/26	Work had been undertaken on the Sexual Safety Charter, and a self-assessment had been completed with work underway on the development of a standalone policy for this.
107/26	A report had been received from the Guardian of Safe Working, and the Committee was informed of challenges in relation to space, however actions were in place to make the required improvements to mitigate any risk. This also linked to the Resident Doctor 10 Point Plan.
108/26	The Group Absence Management Policy would go live from April 2025 and there had been a pause in the behaviour framework, in recognition of winter pressures and ongoing consultations.
109/26	The Staff Survey response rates had increased significantly by 12% on the previous year and action plans were being monitored by the Committee, with the estates team making significantly good progress.
110/26	The Committee would continue to provide oversight on the actions following the NHSE letter on NHS Racism and Anti-Semitism.
111/26	Employee relation activity was on an improving trajectory with a reduction in open cases and a reduction in the length of time cases were taking to close. Data would be included in future reports relating to professional regulator cases across the Group.

112/26	The Committee had received two positive staff stories based on international recruitment and through the CODE/REACH Network, which would be shared with the Board at future meetings.
113/26	The Group Chief People Officer offered an update on workforce controls, where work was continuing with managers on the vacancy control process and weekly meetings remained in place, supported by a full Quality Impact Assessment (QIA) process. There was also the opportunity for staff to escalate vacancies that required prioritisation, due to patient safety where required, which had not needed to be enacted yet.
114/26	The Sexual Safety Charter principles were now embedded and fully implemented across the Group. A letter had been received from NHSE in December 2025 requesting further support in terms of escalation for Board oversight on any cases that may or may not fall under the sexual safety principle. Specialist training for managers was being arranged in this area and data would be presented to the Committee on a quarterly and annual basis. The next steps would include ensuring the policy was approved for publication during quarter four and an annual deep dive would be undertaken.
115/26	The Group Chief People Officer provided an update on the flu vaccination rates, explaining that there had been good performance and as such new stretch targets had been introduced of 55% for LCHS, which had already been exceeded with performance now at 58.9%, and from an acute perspective the target was 60% and was currently standing at 55.6%. The Group Chief People Officer explained that a lot of planning had been undertaken to improve the vaccination rates in year, and Executive colleagues had also supported with the campaign.
116/26	The Group Chief Medical Officer provided an update on the Resident Doctor 10 Point Plan, offering that a submission had been made to NHSE and separate meetings had been held with the NHSE Regional Representation regarding outstanding actions which had been positively received. Several positive improvements were highlighted against the baseline survey. Many of the requests of the initial letter had been completed and work was well underway with completing further work as required.
117/26	The Group Chair thanked colleagues for the work undertaken on the Sexual Safety Charter which demonstrated good progress was being made and thanked the Group Chief Medical Officer for the update on the 10 Point Plan, and acknowledged the positive feedback received on the actions being taken. The Group Chair offered thanks to the Resident Doctor Peer Representative for the work he had undertaken thus far and looked forward to seeing him at a future Board meeting. The Board: • **Received the assurance reports**
	Item 10 Strategic Aim 3 Population
118/26	**Item 10.1 Assurance and Risk Report from the Integration Committee** Mrs Brown provided the assurances received by the Committee at the meetings held in November and December 2025 noting there were no upward escalations to the

	Board, however there had been a referral to the Quality Committee in respect of neurology services.
119/26	Mrs Brown advised that the November meeting had been utilised for an annual review of key areas for the Committee including what further work could be done to improve delivery of significant transformation programmes and what support was required from the Committee, recognising the work that had already been achieved in this area.
120/26	At the December meeting, the Committee received an update on the new space utilisation booking system which was seeing improvements in the acute setting and would be rolled out to the community element of the Group shortly. An update had also been received on the draft Annual Plan along with an update on phase one of the Newton Diagnostic Flow work between July 2025 – October 2025.
121/26	The Committee also received an update on the proposed way forward of the renewal of the Partnership Plan which would be presented to the Board today.
122/26	An update had been received from the Digital Oversight Group and there were areas to note relating to steps being taken to ensure business continuity plans were updated, robust and fit for purpose.
123/26	The Electronic Patient Record (EPR) was red rated due to the requirement to reset the phasing to ensure full understanding of the workings of the EPR, which would in turn enable the organisation to move this forward at pace. The Board: • **Received the assurance reports noting there were no escalations** • **Noted the EPR position**
124/26	**Item 10.2 Partnership Plan** The Group Chief Integration Officer presented the report and offered that due to the changing landscape and well-led feedback received, it was appropriate to pause and reset this work rather than complete the final year of the three year plan. A new plan would be built based on the timelines set out within the report.
125/26	The Group Chief Integration Officer reminded Board members that it had previously been agreed to only have one Strategy, and all others would move to different naming conventions, and explained when those documents would be received. Work was still on track for quarter four delivery including closing any gaps in respect of the well-led action plan. The Board: • **Received the report and supported the recommendations**
126/26	**Item 11 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.
127/26	The Group Chief Nurse provided an update on community pressure ulcers where a deep dive have been undertaken using a combined human factors approach to provide a more comprehensive understanding. The outcomes of this would be utilised to refresh the action plan that would feed into the Quality Committee to provide assurance on the actions being taken.
128/26	In relation to the SHMI, the Group Chief Medical Officer advised that the target related to the SPC was not the correct way to assess any organisation against the SHMI. Assurance had been provided that the figure had been within expected limits for several years and there had been an improving position over the last eight to nine months. The current dashboard related to the previous target and would be updated moving forward.
129/26	The Group Chief People Officer provided an update on vacancy rates and explained an outlying position was being seen as a direct impact of the processes put in place. From a sickness perspective, seasonal peaks had been seen, in line with the national position however the Group was now in a recovering position following the November/December timelines. The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
130/26	**Item 11.1 Strategy Delivery Q2 Assurance Report** The report was presented which demonstrated performance against the strategy framework and good progress was being made against all measures. The Group Chief Integration Officer advised of a good position on the metrics for strategic aim one – patients relating to waiting times, productivity, efficiencies and estates. The Board: • **Received the report offering substantial assurance**
	Item 12 Risk and Assurance
131/26	**Item 12.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the new style report and highlighted that the Risk Register had now been mapped against the previously agreed risk appetite for the Group. For some of the strategic objectives there were several risks which were outside of the risk appetite and the Group Chief Clinical Governance Officer advised that this report leant itself for further discussions.
132/26	Overall the number of risks at high level was not changing, however the report showed that there were some risks to concentrate on in much more detail to understand what could be done in terms of mitigations and to re-look at those areas, in line with the risk appetite to determine whether that was correct.

133/26	Work would continue with each of the Board Committee Chairs and Executive leads to ensure the correct level of discussion and oversight took place around the risks and a future Board Development Session was proposed on risk and risk appetite going forward.
134/26	The Group Chair expressed a view that a Board Development Session on this was required, and it was agreed to schedule this into the programme. **Action: Group Director of Corporate Affairs, 3rd March 2026**
135/26	The Group Chief Integration Officer commented that this did not cover the programme risks, given the size of the programmes and further discussion would be required in respect of whether the programme risks should be included as an appendix to future reports. The Group Chair agreed with this suggestion, given the size of the programmes. **Action: Group Chief Clinical Officer/Group Chief Integration Officer, 3rd March 2026** The Board: • **Accepted the risks as presented noting the significant assurance**
136/26	**Item 12.2 Board Assurance Framework** The Group Director of Corporate Affairs presented the 2025/26 Board Assurance Framework as considered by all the Committees during November and December 2025.
137/26	A recommendation had been made from the Finance and Performance Committee relating to 1d – provision of modern, clear and fit for purpose care settings, to move the risk rating to high from very high, based on the improved oversight and assurance received.
138/26	The Group Director of Corporate Affairs added that the outputs from the workshop sessions of the Quality and Integration Committees were being worked through and would feed into the document. The Board: • **Accepted the 2025/26 Board Assurance Framework which provided substantial assurance** • **Supported the reduction in risk scoring for 1d**
139/26	**Item 12.3 Board Forward Planner** The Forward Planner was presented and received for information. The Board: • **Received the Board Forward Planner**

140/26	**Item 13 Any Other Notified Items of Urgent Business** No further items were discussed.
141/26	The next scheduled meeting will be held on Tuesday 3rd March 2026 via MS Teams live stream.

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

PUBLIC BOARD IN COMMON ACTION LOG

Agenda item: 5.1

Trust Board date	Minute ref	Subject	Explanation	Assigned to	Action due at Board	Completed
6 January 2026	046/26	Group Model Workstream Progress Briefing	Milestones to be included within the next iteration of the report	Group Chief Executive	3 March 2026	Completed
6 January 2026	134/26	Group Risk Report	Board Development Session to review risks and risk appetite to be arranged	Group Director of Corporate Affairs	3 March 2026	Completed
6 January 2026	135/26	Group Risk Report	Programme risks to be included within future Group Risk Reports to the Board	Group Chief Clinical Governance Officer/ Group Chief Integration Officer	2 March 2026	Completed

NHS
Lincolnshire Community and Hospitals NHS Group

Group Chair Arrangements

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3rd March 2026*
Agenda item number	*6*
Report title	*Group Chair Arrangements*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Information
Accountable Director	*Elaine Baylis, Group Chair*
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	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *Note the arrangements in respect of Group Chair from 1st 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:	
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

At the 31st March 2026 the Group Chair, Mrs Elaine Baylis will reach the end of her term of office as Group Chair. NHS England have agreed interim arrangements for the role of Group Chair for a 6 month period from 1 April 2026 until 30 September 2026.

Mrs Rebecca Brown current Group Deputy Chair will step into the role of Acting Group Chair from 1st April 2026.

Moving forward arrangements will be made by NHS England to recruit into the role.

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	*3rd March 2026*
Agenda item number	*7*
Report title	*Group Chief Executive's 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 November and December 2025*

Assurance Rating Key:

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

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

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

System Overview

a) Services across the Lincolnshire health and care system have been extremely busy over January and February with high levels of demand and significant operational challenges across our services. We have seen a 5.78% increase in Emergency Departments and 1.23% in UTCs in activity across the urgent and emergency care pathways. I would like to formally recognise and thank all our teams for their exceptional hard work, professionalism and resilience.

b) Following a major service redesign delivered through the CLEAR (Clinically led workforce and activity redesign) Programme, stroke care across Lincolnshire is undergoing significant transformation. This work will improve patient outcomes, reduce length of stay, and enhance community-based rehabilitation and support. Through a system-wide approach, the programme has enabled United Lincolnshire Teaching Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) to streamline pathways, strengthen multidisciplinary working, and redesign both acute and community stroke services. As a result, the Lincolnshire system is now better positioned to deliver more responsive, coordinated and high-quality stroke care that supports recovery across the entire patient journey.

c) As part of the NHS England regular series of engagement activities with Chief Executives and Chairs, I 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.

d) 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. It focuses on five key areas of clinical practice, including improving access to urgent obstetric and maternal medicine services, strengthening the monitoring and management of maternal deterioration, and enhancing support for maternal mental health. The Group's maternity and neonatal services are actively working to ensure this framework is fully embedded across the organisation, with work underway to align local pathways, training, and governance to the national requirements.

e) Glen Burley, NHS Financial Reset and Accountability Director, wrote to all Chief Executives and Medical Directors outlining the proposed additional specialty recruitment round for 2026. This initiative is 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. Our Chief Medical Officer is leading our response to this ask.

f) The British Medical Association (BMA) has written to all NHS Trusts, confirming that following their recent ballot, which closed on 2 February 2026, resident doctors have voted in favour of further strike action. The Group is currently awaiting additional information and guidance from national bodies to assess the potential impact and plan accordingly.

g) The National Cancer Plan for England was launched in February, which provides 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. Cancer services across the Lincolnshire system are already delivering many of the plan's priorities, including strengthened diagnostic capacity through Community Diagnostic Centres, extended imaging and endoscopy hours, and streamlined pathways such as teledermatology and FIT testing.

Group overview

a) During January, an executive-to-executive meeting took place between the Group and St Barnabas Hospice, providing a valuable opportunity to strengthen our relationship 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.

   The meeting was constructive and reaffirmed our mutual commitment to working more closely to support the communities we serve. It was agreed that a further session would be arranged later in the year to continue developing this partnership and to progress the areas of joint work identified.

b) Since the last Board meeting, the Group has continued to meet with the NHS England regional team as part of the monthly Provider Review Meeting cycle. These discussions have remained constructive providing a regular forum to review progress, discuss emerging pressures, and ensure alignment with regional priorities and expectations.

   The regional team has acknowledged the Group's improvements across operational performance. In addition, the Group's continued focus on financial discipline and delivery has been recognised, with further assurance given regarding the actions in place to support in-year and longer-term financial sustainability.

   The meetings continue to play an important role in maintaining transparency, reinforcing accountability, and supporting a shared understanding of risks and opportunities across the system.

c) The Group have now submitted our final five-year narrative plan in line with the 2026/27 national planning guidance, alongside our detailed finance, workforce, activity and performance plans. The plans set out clear and deliverable actions for performance recovery, productivity, and our wider efficiency and CIP programmes.

d) A final report has 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 provide strong evidence and assurance of compliance across the majority of standards reviewed. Inspectors highlighted numerous areas of good practice, recognising the commitment to continuous improvement, particularly through the effective use of audit. Staff engagement throughout the inspection process was commended, and the collaborative working across multiple disciplines within the services was noted as a key strength. The Group will submit its improvement action plan in accordance with the required IR(ME)R timescales.

e) 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 our subsequent baseline compliance submission, a 12-week progress survey was completed in December 2025. The results demonstrate significant organisational improvement, with compliance now at 81%. Further work is planned to support continued progress and ensure sustained compliance with the 10-point plan.

f) The Group has 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 is scheduled to begin on 5 March 2026. This £24.9 million purpose-built facility will significantly expand diagnostic capacity for the county, providing additional X-ray, CT, MRI and general medical ultrasound services.

g) In parallel, the extension to the Lincoln CDC remains on track, with a go-live planned for April 2026. The £4 million extension will be used to deliver more planned care, including some elective orthopaedic clinics, which will relocate from the Outpatients Department at Lincoln County Hospital.

h) Following NHS England's announcement earlier this year regarding changes to the Bowel Cancer Screening Programme, the Lincolnshire Bowel Cancer Screening Team who are based at ULTH, will be among the first wave nationally to introduce the lowered threshold for home testing kits. This change will support earlier detection of potential signs of bowel cancer and improve outcomes for patients. The home-testing kit, known as the faecal immunochemical test (FIT), is offered to all people over 50 years old and checks for blood in a small stool sample.

i) The Community Tuberculosis (TB) team were recently invited to attend the National Tuberculosis Summit on 26 February 2026 to showcase their improvement programme, which focuses on online consultations and wider digital innovations. As part of the service redesign, an online consultation pilot has been implemented, offering video appointments as an additional option for TB consultations. Early outcomes from these changes include improved patient access, reduced travel time, and greater flexibility in how patients receive care.

j) ULTH has 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 will provide an accountable and transparent source of BNG Units to offset the environmental impact of the new Endoscopy Unit at Lincoln County Hospital. We will be planning 100 trees as part of the orchard, planting starts towards the end of 2026. Through this approach, the Group will meet regulatory requirements while also ensuring long-term, measurable benefits for wildlife and habitats across Lincolnshire, supporting our wider green agenda. This partnership not only contributes to improved healthcare for the residents of Lincolnshire but also helps protect and enhance the natural environment, creating a more enhanced and biodiverse place for local communities to enjoy.

k) Finally, the Board is asked to note that Elaine Baylis, Group Chair, will conclude her term of office at the end of March 2026, having reached the maximum tenure permitted under the relevant national governance frameworks. Today's meeting therefore represents Elaine's final formal meeting of the Group Board.

   Elaine has 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), Elaine has provided continuous and steadfast leadership across more than a decade of significant organisational change. Her deep understanding of the Lincolnshire health and care landscape, combined with her commitment to collaborative system working, has been instrumental in shaping the Group's strategic direction and strengthening its partnerships.

   Throughout her tenure, Elaine has demonstrated exceptional leadership, professionalism and integrity. She has provided clear strategic oversight during periods of complexity and challenge, promoting a culture of accountability, compassion, and continuous improvement. Under her stewardship, the Group has 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 have been widely recognised and valued by colleagues across the organisation and the wider system.

   On behalf of the Trust Board, I wish to formally record our sincere thanks to Elaine for her distinguished service, her exemplary leadership, and her unwavering dedication to the population of Lincolnshire. Her legacy will continue to shape the organisation's development and provide a strong foundation for future progress. The Board extends its warmest wishes to Elaine for the future.

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Development: Delivery Plan Closure Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3rd March 2026*
Agenda item number	*7.1*
Report title	*LCHG Development: Delivery Plan Closure Report*
Report Purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Discussion*
Accountable Director	*Professor Karen Dunderdale, Group Chief Executive*
Author(s)	*Jayne Warner, Group Director of Corporate Affairs*
Financial implications, if applicable	*As detailed within individual actions*
Action / decision required	*The Board is asked to:* • *Receive the closure report of the group development programme plan and note the final position of completed actions and the movement of remaining programmes of work to business as usual or continuing alternative work programmes.*

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

Executive Summary

Background & Introduction

This report has provided a high-level briefing on progress against delivery of the agreed group development programme milestones. As the Group arrangements move into business as usual it has been agreed that the work programme will be absorbed into alternative ongoing work programmes and will no longer be presented to Board.

Current Position including Issues for Escalation

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

In the main, slippage on agreed timescales for some actions remains as previously reported. Those areas rated as Blue are confirmed as being progressed as part of ongoing programmes of work and/or have reverted in to BAU. Timescales and details of actions within this plan have been reviewed and recast as necessary during the movement to ongoing programmes of work, which may inevitably have created differences in some elements of the narrative between plans.

Board Action Required

The Board is asked to:
· *Receive the closure report of the group development programme plan and note the final position of completed actions and the movement of remaining programmes of work to business as usual or continuing alternative work programmes.*

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Complete the group executive leadership recruitment process including the development of an appropriate induction programme and agreement of the contractual arrangements for the new group executive roles Complete the Fit & Proper Person Test (FPPT) checks for all relevant posts and ensure there are arrangements in place for the audit of "processes, controls and compliance supporting the FPPT assessments", in accordance with the NHSE FPPT Framework	31 August 2024 **(initial appointments)**	**Complete:** Appointments made to group executive leadership roles; Testing of FPPT compliance within Internal Audit Programme for 2025/26	
Once the executive leadership recruitment process is concluded, formalise the externally-set executive director statutory & regulatory accountability roles (to be reviewed alongside executive portfolios)	30 September 2024	**Complete:** Externally set executive director statutory roles reviewed and formalised to reflect the new leadership structure and shared at board. Schedule recently updated to confirm that the Group Chief Medical Officer is the executive (clinical) lead for medical devices in line with current national guidance	
Formally approve the overarching group model structure and associated implementation plan including the proposed re-design of the existing directorates to introduce a new Alliance Division as part of an enhanced collaborative operating model, enable each division / directorate to operate on a wider footprint and ensure that clinical leadership remains central to the group model as a key function of group leadership	31 December 2024 **(socialise & engage)** 4 March 2025 **(board approval)** 1 April 2025 **(implementation)** **30 June 2025 (embedded)**	**Complete:** Operating model socialised through the re-launched Group Leadership Team (GLT) and implementation plan developed. Final operating model approved by the board in May 2025 and being communicated and embedded	
As part of the work to finalise the wider group and directorate structures, agree the division / balance of roles & responsibilities at group and trust level including alignment with Place, supported by the development of a clear Accountability & Performance Management Framework and aligned governance & decision-making processes and arrangements	As above		
Implement and embed the new operating model and leadership structure, Performance Management & Accountability Framework and associated governance arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	**Complete:** As above. PRMs are now in their sixth cycle and are scored as per the Performance Management & Accountability Framework **(but see also work stream 2)**	
Align the group support services and associated policies, processes and arrangements	1 April 2025 **(implementation)** 30 June 2025 **(embedded)**	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Once all of the required changes to the trust's operating model including leadership and governance & decision-making arrangements have been made, communicate to staff across the group - to include the development of a simple visual representation of the trust's operating model and updating & reissuing of the '*Governance Framework – A Reference Guide for Staff*'	1 April 2025 & Ongoing	**Complete:** Comms cascade undertaken through GLT roadshows. Visual representation of Operating Model uploaded to the Group Intranet. *Governance Framework – A Reference Guide for Staff* updated	

Work Stream 2: Accountability, Information & Reporting

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Design, approve and implement an Performance Management & Accountability Framework for the group which: • is aligned to the aims & objectives of the group and strategic partners; • is aligned to the relevant statutory and regulatory standards, requirements and contracts relevant to the trusts and wider group; • flows from ward / patient to board; • is aligned to and supports the board and board committee cycle; • is based on clear metrics with defined performance thresholds reported through a harmonised Integrated Performance Report (IPR) from a group, trust directorate & service perspective; • is balanced across strategy, quality & safety, performance: operational delivery, workforce, finance, governance & risk; • is underpinned by a harmonised accountability & performance review policy & process; • is action focussed in support of delivery and risk mitigation and which reflects best practice as set out in the latest NHSE guidance: 'The Insightful Provider Board'; [**Note:** There is a need to ensure relevant improvement programmes e.g. ULHT Integrated Improvement Plan (IIP) is integral to and not separate from the above process including the alignment of group / trust KPIs]	**Performance Management & Accountability Framework:** 31 January 2025 **(draft outline)** 28 February 2025 **(socialise)** 3 March 2025 **(approval)** 1 April 2025 **(implementation)** 30 June 2025 **(embedded)** **Final Metrics / Alignment of IPR:** 31 August 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Review the BI resource across the group to ensure this remains effective in support of the Performance Management & Accountability Framework and the accurate, effective and timely reporting on performance and as part of the 'Vision for Information'	20 December 2024 **(Draft Vision)** 31 March 2025 **(Final Vision and Structure Proposal)** 30 April 2025 **(approval of structure)**	**Complete & ongoing:** Structure agreed. Director of Digital in post from 1 April 2025. Director of Performance Intelligence to go out to advert imminently. New performance information system now developed and being deployed (RACH). Next step is to deploy RACH to support PRMs and the IPR for board Group structure in draft format (Dec-25) pending budget review and senior structure work.	

Work Stream 3: Aligned Governance & Decision-Making

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Board & Committee Governance			
Complete the transition from boards-in-common to a joint or group board (once all appointments have been made to group executive leadership roles and NHSE approval has been received for the appointment of joint or group and trust specific Non-Executive / Associate Non-Executive Directors (NEDs / ANEDs)	30 November 2024 **(complete – joint Trust Board in place)**	**Complete:** Group Board in place. Board Development Programme also in place supported by NHS Providers who have provided some initial observations and recommendations for strengthening the operation of the board – relevant actions incorporated within the group development programme plan. Well Led Assessment also planned for 2025 with NHS Providers support. Terms of Reference for Well Led Assessment drafted and assessment commenced	
Complete the work to align the board business cycle (work plan)	31 December 2024 **(drafted)** 31 January 2024 **(approval)** **3 March 2025 (revised timescale for approval)**	**Complete:** Board business cycle for 2025/26 approved by Group Board in March 2025	
Complete the work to transition the remaining board committees (Audit & Risk, People / Workforce, Finance & Performance) to work jointly including the development and approval by the trust board of harmonised terms of reference & work plans and the agreement of any changes to the naming convention for these committees. The development of harmonised terms of reference and work plans for all board committees to include a review of: • delegated authority and matters reserved to the Group Board; • membership (reflecting changes to group leadership structures); • reporting up from sub-groups (reflecting any changes to and / or alignment of those groups) • assurance ratings (ensuring these are aligned and consistent with those within the BAF) • the development of an 'Assurance Map' detailing the areas of oversight covered by each of the board committees; not least to avoid duplication and gaps	31 December 2024 **(harmonisation & approval of terms of reference & work plans & transition to new ways of working for all board committees)** 1 January – 31 March 2025 **(implementation)** **6 May 2025 (final terms of reference & work plans submitted to board)** 30 June 2025 **(arrangements fully embedded)**	**Complete:** Committees are now meeting jointly although arrangements continue to be embedded Terms of reference and work plans refreshed to reflect the new group strategic aims & objectives and approved by the Group Board in May 2025 (together with the 'Assurance Map', 'Board & Board Committee Principles Framework) 'Assurance ratings within the BAF have been reviewed and wording updated. Assurance ratings used within reports to the board and board committees have also been updated as part of the strengthening of the board & board committee templates Review of groups reporting into board committees is also complete. (The review of sub-groups reporting into those groups is a separate piece of work as part of BAU)	
Undertake a review of the operation and effectiveness of the Quality Committee nine months on and any required changes to the terms of reference, work plan & associated arrangements. Any learning to be used to inform the transition of the remaining committees to working jointly **[NB.** Independent testing of the operation and effectiveness of all board committees working jointly will be required once embedded. This could be as part of the Internal Audit or planned Well Led Assessment.]	31 October 2024 **(review complete)** 31 January 2025 **(board receipt of & implementation of recommendations)**	**Complete:** Review of Quality Committee undertaken with support from Interim Governance Advisor and recommendations accepted and shared with the Group Board. Some changes made to reporting groups. Arrangements to be reviewed again in 12 months. Learning from the review is being used to inform the transition of the remaining board committees to working jointly	
Develop and seek approval from the trust board of terms of reference and a work plan for the proposed joint Integration Committee and agree the date for these meetings to commence and the required frequency	30 November 2024	**Complete:** but see also comments above on the need for embedding of all joint board committees	
Develop a 'board & committee principles framework' to ensure there is collective understanding of joint working principles; that both trusts can continue to make decisions and operate in accordance with the statutory & regulatory requirements that apply to them; and there is continued robust corporate reporting	31 December 2024 6 May 2025 (submitted to board)	**Complete:** 'Board & committee principles framework' drafted and approved by the Group Board in May 2025	
Develop (or make any required changes) to harmonised board & committee templates (report cover / front sheet, agenda, minutes, upward report & action log) and common report writing guidance in light of the move to group and working jointly. As part of the development or updating of the report writing guidance, consider the need for and introduce a programme of report writing training for key staff and develop an exemplar report front / cover sheet	28 February 2025 **(templates & guidance)** 31 March 2025 **(training plan drafted)** **6 May 2025 (submitted to board)**	**Complete** Revised suite of upward report and report templates and report writing guidance developed and published.	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Non-Executive Director (NED) & Associate Non-Executive Director (ANED) Roles			
Complete the review of proposed NED / ANED roles for the group and secure the required internal and external approvals [**Note.** This is required to facilitate a formal move to a joint or group board and joint committees rather than 'in-common' board and committees]	30 September 2024	**Complete:** review of NED / ANED roles complete. Approvals received and arrangements effective from 1 October 2024 NHSE approval also received for the appointment of an additional NED who is now in post. Additional NED is a full NED on the ULTH board and an Associate NED on the LCHS board. This additional appointment reflects the award of teaching hospital status to ULTH	
Board Development			
Once the group executive leadership team is in post and informed by a board skills & knowledge assessment and aligned to the proposed group executive development programme, develop, agree & implement a Joint Board Development Programme. As an outline, a Board Development Programme may typically include: • board development days / time-outs ensuring dedicated time on key topics and priorities including group development and strategy; • information sharing / briefings (e.g. national policy, regulatory changes, learning and good practice from elsewhere); • board training / compliance requirements; • tailored sessions in response to identified development needs (including those identified from the skills & knowledge assessment or arising from the annual review of board effectiveness or any well led or governance review etc.)	From 1 October 2024 onwards	**Complete & ongoing:** Board Development sessions being undertaken with NHS Providers support Formal programme for 2025/26 drafted to ensure appropriate focus on strategy and long term service development, the role of the unitary board, the board's appetite to risk, working with system partners and the board's responsibilities in respect of EDI and health inequalities (NHS Providers Board Effectiveness Survey, November 2024 refers) Programme shared with the Group Board in May 2025	
Consider undertaking an annual board maturity assessment which in turn will contribute to any well led assessment and will inform the board development programme for the following year	31 March 2025	**Complete:** Well Led Assessment, which is being undertaken by NHS Providers, commenced in June 2025 and is expected to last 3 months. Feedback to Board planned in Nov 25	

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

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

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

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

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Document Control & Policy Approvals			
Agree and implement a harmonised and strengthened approach to document control and policy approvals for the group	Policy & Policy Approvals: 31 March 2025 **(policy in place) - complete** 31 June 2025 **(embedded) – not yet complete** Compliance 30 September 2025 **(agreement of improvement plan & trajectories)** 31 March 2026 **(improved performance)**	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Review of Key Trust Documents & Governing Instruments			
Complete the review, alignment and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Orders • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Boards • Division of Responsibilities Schedule between the Group Chair and Chief Executive • Performance Management & Accountability Framework • Fit & Proper Persons Policy & associated processes Other trust documents to be aligned as part of work to implement the directorate structures and align the group support services and to socialise / launch the group brand	25 July 2025 **(Audit Committee)** 2 September 2025 **(Group Board approval)**	**Complete:** Interim amendment to Standing Orders made to reflect the appointment of a Group Chief Executive and joint Leadership Team, changes to ELT and GLT decision-making and the proposed move to joint board and committees and any changes to voting rights A joint Fit & Proper Persons Policy is in place for the group but will need to be refreshed to ensure alignment with the newly published Board Member Appraisal Framework Performance Management & Accountability Framework drafted and approved by GLT on 4 April 2025 and by the Group Board on 6 May 2025 Final amendments to the Standing Orders (including the Division of Responsibilities Schedule), Standing Financial Instructions and Scheme of Delegation approved by the board on 2 September 2025	
Review and update relevant policies, documentation and templates to reflect the move to group and the group brand	As above	As above	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Working Agreements			
Review and update the Group Partnership Agreement to reflect the agreed changes to the operating model including the leadership and governance & decision-making arrangements, once finalised and agreed	2 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Review and update the Group Workforce Sharing Agreement to reflect the agreed arrangements for broader staff / staff groups from each trust, as required, to work across the group: such arrangements to maintain the existing employment relationship whilst avoiding the need for honorary contracts or secondment agreements	2 September 2025	As above	
Review and update the Group Information & Data Sharing Agreement to reflect changes to the operation of the group and any changes to the requirements for sharing information & data	2 September 2025	As above	

Work Stream 4: Communications & Engagement

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

Work Stream 4: Communications & Engagement cont'd

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Group Intranet & Internet			
Create and roll-out a group Intranet (including the migration of ULTH to nhs.net). **[Note:** All staff across the group to have access to the group Intranet from 1 April 2024. Full migration to nhs.net to take up to a year]	30 June 2025	**Complete:** LCHS staff now have access to ULTH intranet which became the group intranet from 6 August 2025	
Create a single group three URL website which provides information at both a group and individual trust level and which meets accessibility legislation requirements	31 March 2026	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Communications & Engagement Team			
Continue to embed and develop the combined group Communications & Engagement Team building on the implementation of cross-group portfolios from September 2024	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Continue to provide communications & engagement support, as required, to the group development programme work streams & SROs e.g. development of group strategy, aims & objectives, values and culture	31 March 2026	**Complete:** Comms & engagement support in place and ongoing	
Continue to embed the merged media monitoring / horizon scanning and escalation process	Ongoing	**Complete:** Ongoing – group wide media monitoring / horizon scanning and reporting to the Group Chief Executive and GLT is in place	

Work Stream 5: HR & Workforce

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Continue to provide ongoing support to those staff most affected by the move to a group model	Ongoing	**Complete & Ongoing:** Engagement 'Tube Map' and Change Workshops in place & ongoing **(Appendix C refers).** Additional staff / GLT engagement roadshows held during May & June 2025	
Develop proposals for a long term Organisational Development programme to support the transition to group and the new operating model with a focus on: • Directorate leadership development • Executive development • Board development	Ongoing **(Group Board and ELT) Development Programmes)** 31 March 2026 **(Division / Directorate Leadership Programme (The 'Leeds Way') to be embedded**	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Continue to align and develop the group culture including the agreement of one set of group values	31 January 2025 **(outputs & recommendations from 'Better Together' Programme & engagement sessions)** 3 March 2025 **(board approval)**	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Continue to develop the staff health & well-being offer across the group including the introduction of menopause support	31 May 2025	**Complete & ongoing:** The LCHG staff health & well-being offer continues to be developed and harmonised across the group. The menopause service was extended across the group in July 2025 and is now available to both ULTH and LCHS staff	

Work Stream 7: Digital

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

Work Stream 7: Digital cont'd

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
• transition LCHS from the current AGEM IT support contract to the Group Digital support system - **Scope expanded to align novation of service for ICB and Primary Care (GP IT)**	24 January 2025 **(Finalised Plan)** 1 November 2025 **(Full Service Migration – some things may take longer)** 1 November + 12/18 months – **(integration and optimisation of service)**	**Complete & ongoing** – work continues to optimise and standardise processes • 28 WTE colleagues from AGEM TUPE'd to ULTH from 1st November. • AGEM / Group consultation process completed 17th October. • LCHS AGEM Digital service partially transfer to in LCHG in house provision on 20th November. • Full AGEM transfer completed 1st November. • Due to significant expansion of scope, the work to optimise the digital services will continue over a 12-18 month period, post AGEM transition.	
• create a common identity for the Digital Team (linked to the group brand & associated actions)	31 October 2025 (due to merger of LCHS and GPIT teams)	**Complete & ongoing** – work continues to optimise and standardise processes LCHG Digital consultation completed 1st December. Full system digital alignment plan in place and underway Linked to AGEM transition – team brand to be LCHG Digital Services, with associated new uniforms and logos being created.	
• develop a 'Vision for Information' for the group including a review the Business Intelligence (BI) resource across the group to ensure this remains effective in support of the group Performance Management & Accountability Framework and the accurate, effective and timely reporting on performance	31 March 2025 30 April 2025 **(agreement of structure)**	**Complete & ongoing:** Structure agreed. Director of Digital in post from 1 April 2025. Director of Performance Intelligence to go out to advert imminently. New performance information system developed and being deployed (RACH)	
• move to aligned telecoms	30 May 2026 **(Secured single contract for Telephony Services)**	**Complete & ongoing** : • Single team lead in place, new group contract in place for 12 months • Plan to move LCHS to current ULTH system to deliver saving • Procurement of required group level services planned during 2025/26 into 2026/7 • Finalisation of roles as part of integration of LCHS and ULTH digital teams being planned as part of structure	
• data hosting	31 October 2025 **(AGEM project closure)** End January 2026 **(completion)**	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	

Work Stream 8: Estates & Facilities

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Estates Strategy, Service Developments & Transformation			
Develop the Estates Strategy in support of delivery of the agreed group strategic aims & objectives, planned service developments & transformation projects and in support of reducing health inequalities:	31 March 2025 **(commencement of work to develop the strategy)** 2 September 2025 **(board approval)**	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• consider & evaluate the different models for the provision of EFM services across the group to include the option of a wholly owned subsidiary model and present the findings and recommendations for approval to the Group Leadership Team and Trust Board	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• undertake an estates rationalisation review with a focus on decompressing the acute site and agile working and present the findings and recommendations to the Group Leadership Team and Trust Board. This work to be undertaken in line with "left shift" proposals	30 June 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• continue the programme of ward refurbishments, as funding is available	Ongoing	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• undertake a review of all leases and licences across the group	30 June 2025	**Complete & ongoing:** All LCHS leases now obtained. New MOTO being negotiated with NHSPS which will move a number over to being in place and compliant. In respect of ULTH, there are a number of minor occupancies to work through and formalise. New Property Manager being recruited and will lead on this area of work	
• produce a visual 'map' of all services and where they sit within the group and ensure this is aligned with each trust's CQC registration / Statement of Purpose'	31 December 2024	**Complete:** 'Map' of services produced and shared with ELT	
• deliver the agreed 2024/25 EFM transformation projects and EFM improvement plans	31 March 2025	**Complete:** Plan and projects delivered for 2024/25. Plan in development for 2025/26	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Restructure of EFM			
Complete the restructure of the EFM senior management team and underpinning workforce plans and associated work plans to ensure the two trusts are able to meet and, where necessary, improve compliance with statutory requirements to include the bringing together of the emergency planning and health & safety teams	31 August 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Equality & Inclusion			
Continue to promote equality & inclusion and reduce workforce inequalities within EFM:	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• develop a single approach to the movement of EFM staff across the group	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• commission a cultural review of estates services and continue to deliver the improvement actions identified in the facilities services cultural review	30 September 2025	**Complete & ongoing** Facilities (Housekeeping) Cultural Review completed Scope for wider review being finalised.	
• align and improve the processes for staff development, on boarding etc. across EFM	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
EFM Governance & Assurance			
Undertake a review of and strengthen the EFM governance structure and associated assurance processes across the group and ensure that the EFM governance structure is appropriately aligned to the wider group governance structures and decision-making arrangements:	30 September 2025	**Complete & ongoing** – EFM Head of Compliance recruited. Also linked to future EFM model. Full group PPM audit. Safety Groups in place, Group Health & Safety Committee in place	
• align the process for the completion and submission of the annual Premises Assurance Model (PAM) assessment and for monitoring delivery of the agreed improvement actions	30 September 2025	**Complete** Latest NHSE guidance and assessment tool received. Submission 30 September 2025	
• undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• review, update and align the EFM policies and procedures across the group	31 December 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	

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

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
EFM Digital Strategy			
Review the EFM service functions on a service-by-service basis, identify all opportunities to digitalise the process to improve reliability and productivity	30 September 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Backlog Maintenance			
Continue to review the findings of the six-facet survey and identify critical estate infrastructure risks (CIR) across the group	Ongoing	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• using the results of the six-facet survey prioritise the high & significant CIR risks and submit funding bid to the ICB	31 March 2026	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• ensure CIR risks are addressed in respect of any new developments across the sites	Ongoing	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• provide regular backlog maintenance progress reports to the Finance & Performance Committee and Capital & Revenue Investment Group	Ongoing	**Complete:** reporting In place and ongoing	
• ensure all CIR risks are recorded on the trusts' risk registers	30 September 2025	**Complete**: CIR risks added to the risk register.	
Group Asset Register & Planned Preventative Maintenance (PPM) Review			
Review the group assets and ensure a comprehensive and accurate asset register is created	31 March 2026	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• ensure all assets are barcoded and linked to an industry standard maintenance management system	31 March 2026	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
• carry out a review of PPM across the group to improve compliance and productivity	31 March 2026	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	

Work Stream 9: Strategy & Planning

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

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

Key Tasks / Milestones	Timescales	Current Position including agree remedial actions where progress is 'off track'	RAG
Develop a Group Quality Improvement (QI) strategy and commence implementation of the Quality Management System (QMS) as a key enabler to delivery of our productivity and transformation programme. QI strategy to focus on culture/shared purpose/leadership behaviours and a dosing model for building improvement capacity	31 March 2025 (QI Strategy) 31 October 2025 (QMS)	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Develop a proposal for primary, community and acute care collaboration (Alliance Model) and a spectrum of integration	31 March 2025 31 August 2025 (Phase 2)	**Complete:** Alliance Model and programme confirmed and approved via Integration Committee. Communications plan in development for internal awareness. New Terms of Reference to include a review of external members to be received by the Integration Committee in August 2025	
Develop a Partnership Strategy for the group	30 September 2025 30 December 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Support development of the Group Sustainability & Green Plan - Phase 1	31 March 2025 (Phase 1) 2 September 2025 (board approval)	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	
Develop a clinical services and practitioners strategy for the group	31 August 2025	**Complete:** Strategy agreed A detailed model on a health campus approach is being developed for agreement by the end of the financial year.	
Build and shape a new group strategy and planning team with OD support to fully align with required functions	31 August 2025 30 Dec 2025	Being progressed as part of ongoing programmes of work and/or have reverted to BAU	

Work Stream 10: Finance

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

Work Stream 10: Finance

Key Tasks / Milestones	Timescales	Current Position including agreed remedial actions where progress is 'off track'	RAG
Complete the review, harmonisation and approval of key documents & governing instruments to reflect the move to group and changes to the operating model to include but not limited to: • Standing Financial Instructions • Scheme of Delegation & Powers Reserved for the Board	25 July 2025 **(Audit Committee)** 2 September 2025 **(Group Board approval)**	**Complete** Updated Standing Financial Instructions and Scheme of Delegation & Powers Reserved for the Board approved by the group board on 2 September 2025	
Harmonise the financial policies and processes across the group	31 December 2025	**Complete and ongoing** Current financial policies all up to date. Mapping exercise to be undertake to identify those still to be aligned and to agree timescales. Oversees Visitors & Private Patients policy aligned and approved	
Align the Internal Audit arrangements	31 August 2025	**Completed**. Internal audit arrangements have been aligned. A joint Audit Committee is in place with auditors working to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability	
Review, harmonise and strengthen the financial training offer and culture	30 June 2025	**Completed** – First finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025. Ongoing training offer available within ESR	

Appendix A: Group Development Programme: Work Streams & SROs

Work Stream 1: Group Operating Model & Leadership

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

Work Stream 2: Accountability, Information & Reporting

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

Work Stream 3: Aligned Governance & Decision-Making

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

Work Stream 4: Comms & Engagement

SRO: Group Chief Executive

Work Stream 5: HR & Workforce

SRO: Group Chief People Officer

Work Stream 6: Organisational Development

SRO: Group Chief People Officer

Work Stream 7: Digital

SRO: Group Chief Integration Officer

Work Stream 8: Estates & Facilities

SRO: Group Director of Estates & Facilities

Work Stream 9: Strategy & Planning

SRO: Group Chief Integration Officer

Work Stream 10: Finance

SRO: Group Chief Finance Officer

Appendix B: Group Development Programme Delivery RAG Rating

RAG Rating Matrix	
Blue	Actions to be absorbed into BAU or ongoing existing work programmes
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress & on track
Red	Not yet completed / significantly behind agreed timescales

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	*03 March 2026*
Agenda item number	*9.1*

Quality Committee Upward Report of the meeting held on 20 January 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:	03 March 2026
Report from:	Quality Committee
Report from meeting held on:	20 January 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 20 January 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 Upward Report
b) Patient Safety Concerns Raised by Junior Doctors
c) High Profile Cases Report
d) Ophthalmology Waiting List Recovery Update
e) 6-Month Update on Risks and Mitigations Around Unsafe Discharge

The Committee reviewed a 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.

The focused actions being implemented to prevent the occurrence of Level 1 Pressure Ulcers in the community was progressing, with the rate of occurrence reducing from 24% in September 2025 to 7% in November 2025. The promotion of a holistic care model in the community, as part of these preventive actions, was also being supported by the 'District Nursing Transformation Plan'. The Plan will transform and bring the whole community nursing workforce in alignment with the holistic care model and provide the assurance that the right care and ulcer preventative practices were being implemented.

Healthcare Acquired Infections were noted with the E-Coli trajectory continuing to decline but the C.Diff trajectory remained off-track in November 2025.

The Surgical Site Infection (SSI) Quality Improvement Project was progressing with increased orthopaedic consultant oversight and alignment with the orthopaedic surgical pathway. To strengthen SSI surveillance, so evidence-based interventions can be implemented to reduce infection risk, 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 Group's Tuberculosis Service had been invited to present at a Getting It Right First Time (GIRFT) Programme event on the exemplar achievement around the reduction of waiting times. Though referrals had increased by over 33% year-to-date in November 2025, waiting times had declined from 40 weeks in March 2025 to 3 to 4 weeks in November 2025.

Though planned preventative maintenance (PPM) completion was at 92.8% across all acute sites, ventilation remained a significant concern. This was because of ageing theatre ventilation systems and inadequate ventilation in treatment rooms which required substantial capital investment to meet current Health Technical Memoranda (HTM) standards. Mitigation strategies including clinical risk assessments and interim air scrubbing technologies were in place.

The Committee received an update on the actions being implemented to reduce the backlog of waiting patients for 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 can be undertaken.

The Committee was informed that actions to ensure the discharge process for patient into the community was safe had been progressed. One action was the roll out of OPTICA (Optimised Patient Tracking & Intelligent Choices Application), an application which tracks all admitted patients and the tasks relating to their discharge in real-time through their hospital journey. There were pilot projects in place on two wards to test discharge checklists, but LCHS had also partnered with Martha's Rule to develop a well-being questionnaire. Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

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

a) Patient Experience and Involvement Group (PEIG) Upward Report
b) Safeguarding and Vulnerabilities Oversight Group Upward Report
c) Children and Young People Oversight Group (CYPOG) Upward Report
d) Focussed Discussion – Epilepsy

The actions being implemented to improve data collation on Datix so that the occurrence Mixed Sex Accommodation breaches can be reduced was noted to have progressed.

The Safeguarding and Vulnerabilities Oversight Group (SVOG) escalated concern over the potential of a failure to make a Paediatric appointment to the Children Looked After (CLA) 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.

The CYPOG highlighted to the Committee that all the Group's services for Children and Young People were now work strands within the Paediatric Transformation Project. The Project forms part of the wider Left Shift (Acute to Alternative Settings) Programme.

The Committee received a deep dive into the Children's Group's Epilepsy Service which highlighted the enormous potential to implement meaningful change, to improve life opportunities and to reduce the health and social care burdens of the future. The success of the Service was especially important for those children and young people in the most impoverished areas of Lincoln.

The Committee also formally recognised that the Children's Group's Epilepsy Service delivered high-quality care within severe capacity constraints and that the very high-risk score of 20 on the Risk Register was justified.

Assurances in respect of Objective 1a(iii):

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

The Committee noted with concern that Surgical Care Group (SCG) Upward Report to the CEG, that the SCG currently had 181 open local audits, with 142 past their presentation date and 40 overdue actions from 19 audits. Additionally, the actions from the Young People's Mental Health 2019 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study remained outstanding.

Assurances in respect of other areas:

a) Group CQC Visit Update and Proactive Programme of Work including CQC Urgent and Emergency Care (UEC) Action Plan and End of Life Visit Report

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. The aim of the work being undertaken was to move beyond reactive responses to CQC

inspection activity and instead demonstrate that services were consistently well-led with CQC readiness embedded into day-to-day practice rather than driven by inspection cycles alone.

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
- note the escalation made to the Board

Jim Connolly, Non-Executive Director

20 January 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	*3 March 2026*
Agenda item number	*9.1*

Quality Committee Upward Report of the meeting held on 17 February 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:	03 March 2026
Report from:	Quality Committee
Report from meeting held on:	17 February 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 February 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 Upward Report
b) High Profile Cases Report
c) Maternity and Neonatal Oversight Group Upward Report
d) CNST Final Submission

The Committee reviewed a Patient Safety Group 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 whilst changes were made to the Paediatric Cardiology Service to reduce the waiting list.

The Committee was updated on the 'task and finish' group's recommendations which included the implementation of the management processes for managing and monitoring incidents and the expedition of the recruitment to two paediatric cardiologists to maintain service resilience. The Patient Safety Group report also informed the Committee on the significant reduction in the Paediatric Cardiology waiting list.

Healthcare Acquired Infections were noted with the C.Diff infections trajectory remaining off-track with 3 occurrences in December 2025. The Infection Control team had 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 trajectory for E-coli infections continued to improve in December 2025 with 4 occurrences, from the 5 occurrences in November 2025 and the 8 occurrences in October 2025. The Infection Control team's preventive actions were having a positive effective.

In terms of Pressure Ulcers, in December 2025, there were 1.08 occurrences per 1000 bed days of category two to three pressure ulcers. This reflected a continued improvement from previous months.

From the Maternity and Neonatal Group Upward Report, the Committee noted that for the compliance with CNST Year 7 MIS evidence:

a. 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.
- Record in the Group Board minutes that one eligible perinatal death was not 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.

b. CNST Standard 3:

- ATAIN: Note update relating to continuation of the Quality Improvement Project 'Midwives as second checkers for neonatal IV antibiotics.'
- TC: Note governance for transitional care pathways strengthened with actions to be added to the PeriSIP.

c. CNST Standard 4 - Clinical Workforce:

- Neonatal workforce: - Record in Group Board minutes progress against the previously agreed QIS action plan and trajectories and that this is on the services risk register.

d. CNST Standard 5 - Midwifery Workforce:

- Note and record in the Board meeting papers the update on the agreed plan, including timescales, for achievement of the appropriate uplift in funded establishment along with mitigations to cover this shortfall, specifically the following:
  - Ongoing cost pressures managed by the Group.
  - Full review planned for April.
  - Recruitment to 12.1 WTE posts continues.

e. CNST Standard 6 - Saving Babies Lives Care Bundle:

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

f. CNST Standard 7- MNVP: Note the formal escalation of risk, via the PQSM relating to the MNVP provision.

- Record in Group Board minutes that escalation via the PQSM model at Group and LMNS level, reported via MNOG/QC upward reporting process is ongoing with mitigation currently under review to ensure the service continues to listen to women and families in a way that is proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance.
- Note progress with co-produced action plan 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.

g. CNST Standard 9 - Floor to Board:

- Record in Group Board minutes progress with the Staff Experience Group (maternity and neonatal culture plan), specifically: - The staff level launch of the Staff Experience Group

h. CNST Standard 10 - MNSI:

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

To confirm, as compliance with CNST MIS requires full achievement of all elements within each of the ten-safety actions, the Group intends to submit its Group Board Declaration on 26th February 2026 declaring non-compliance with requirement one of Safety Action 1 and, as a result, will have to return a submission of overall non-compliance for the MIS Year 7 scheme.

The Committee recommended that the Group Board approve the declaration of 'non-compliance' with CNST MIS Year 7.

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

a) Patient Experience and Involvement Group (PEIG) Upward Report
b) LHCG Complaints Report Q3
c) Children and Young People Oversight Group (CYPOG) Upward Report
d) UTC Out of Scope presentation in LCHG UTCs
e) Focussed Discussion – Neurology

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

Paediatrics Transformation Project: The LCHG Executive team are still finalising the plans and timelines for which of the Community CYP services currently in Family Health Care Group will transfer into the Alliance Group by the end of the 25/26 financial year. It is expected all the work strands under the Paeds Transformation Project will also transfer across and will continue as planned; further update will be provided at the March 2026 meeting when it is anticipated the decisions will have been made.

Audiology: The terms of reference for the Audiology Review have been amended slightly, informed by the report from EY, an external partner and a revised project plan and delivery timeline is currently being developed.

The Committee received a presentation which highlighted some areas of specific vulnerability and current mitigations in place at the Group's Neurology Service. The Service is currently recognised as fragile, with a risk grading of 20 on the risk register, and note was taken of the need for a full review of the Service in totality

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group (CEG) Upward Report

National Bowel Cancer Audit: - The Committee noted that the CEG had requested for a review of the cohort of patients impacted in the two areas that the audit had identified the Group as performing worse than the national average: adjusted 90-day mortality following major resection and adjusted 30-day unplanned return to theatre following major resection. The findings from the review will be presented to CEG at its meeting in April 2026.

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework 2025/26
c) Risk Report
d) Policy Position Update
e) LCHG Accreditation Register
f) CQC Update
g) Committee Performance Dashboard (LCHS and ULHT)

The Committee received a presentation on a Patient Story 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 reviewed the Risk Register, including all the high risks and the emerging risks that had been allocated to the Quality Committee.

The Group Accreditation Report stated that to support improved awareness and oversight of external agency visits, the Group's Compliance Team have revised and strengthened the policy relating to external agency visits. The Group Compliance team have also started work to understand what external accreditation schemes are in place within LCHG or that are being worked towards. Additionally, the Compliance Team have also sought to build a greater understanding of what evidence or data is sent outside of the Group for the purposes of regulation or accreditation.

The Committee received the report on a 28 January 2026 CQC inspection undertaken at Boston Pilgrim Hospital which was focussed on 5 medical wards and the Discharge Lounge.

The positive feedback provided after the inspection included that:

- Staff were welcoming, helpful, open and honest;
- Leaders could give clear examples of learning from incidents that had taken place and had a good awareness of the patient safety risks on their wards;
- Staff consistently told us they worked well together and that teamworking was positive;
- Patients, relatives and families were complimentary of the staff and the care they had received on the wards, commenting on how hard staff worked;
- Staff knew their patients and communicated well with them, showing patience;
- There was good monitoring of patient deterioration and understanding of the process, alongside NEWS monitoring;
- There was good sepsis management across the wards;
- Staff had good safeguarding knowledge and knew who to contact for support;
- There was good identification of end of life care patients and they were cared for on the ward when it wasn't possible to transport patients;
- Reports of good support from specialist teams – dementia, tissue viability,
- palliative. And we saw that from a dementia perspective.

The negative feedback provided included that:

- Inconsistency with record keeping and completion of forms - there are pathways, bundles, documents etc, in place to try and mitigate risks. However, these weren't always completed;

    - ReSPECT forms did not always correspond with the mental capacity. However, we were provided with assurance around this post site visit;
    - DoLS pathway was in place but has not been reviewed although a form of restraint is already being used (mittens);
    - We saw mouth care records were in place and hardly completed – as an example it was done the day the form was put in place then not done for the rest of the week;
    - Daily weights had been requested over several days and weren't started.
- Inconsistency with use of certain systems:
    - Falls – falls socks and bands used inconsistently, some wards they were there appropriately and some they weren't, falls forms that were for patients were in the records form;
    - The 'red jug' system – inconsistent use across different wards, whether it be all patients having it, none or used appropriately.
- On the day ward 6A had 10 enhanced care patients, on several occasions, a 4 bedded bay of patients was unobserved. They had to move one of their nurses to another ward to help. That was one less staff member for them when they have 2 patients who were 1:1 and wandering around the ward;
- HCA staffing was the main staffing concern across wards – shortages can have a real impact on patient care;
- No mobile oxygen on wards contributed to a dignity issue for some patients, for example a patient that could use the toilet used a commode as a result;
- Discharge lounge concerns:
    - Inclusion/exclusion criteria – It appeared that there wasn't one necessarily and patients that were not 'for discharge' were in the hospital so it appeared to be more like a ward with a discharge room;
    - Its location in the hospital is quite far from the other medical wards;
    - Patients are staying in there longer than they should be but there is no medical cover to keep assessing patients;
    - Patients are going to the lounge and then returning to wards as they were not medically fit;
    - We heard about concerning incidents but don't have the DATIX for these – there was an incident where staff felt the need to lock themselves in a toilet, and a separate incident where the security assistance took an hour to respond.

The Committee also received the report on an unannounced CQC inspection of the Community Hospitals at Skegness and Louth on 3 and 4 February 2026, followed by further visits to Gainsborough and Spalding on the 10 and 11 February 2026.

The positive feedback provided included that:

- Staff on all wards were welcoming and said they were proud of the care they gave to patients;
- Wards were visibly clean and provided homely environments and a good variety of spaces for clinical and therapeutic interventions;
- We spoke with 19 patients, their feedback was mostly positive, however 3 said wards were sometimes short-staffed which lead to care being delayed;
- We were told about an initiative on Welland ward called Think Drink. Staff had implemented a range of initiatives which improved the levels of

hydration of patients' and achieved positive outcomes in relation to physical health and wellbeing.

The potential areas for improvement were:

- We saw 2 instances where patient care was undertaken in ward side rooms. Staff had neglected to turn the door louvre windows to the closed position. This meant that we could observe hands on clinical interventions, and compromised privacy and dignity;
- We saw staff used an assortment of assessment and patient monitoring forms. The type and number were inconsistent, for example on Welland ward we saw folders which were comprehensive and well organised and included individual Respect forms;
- We had concerns regarding vulnerable patients on Scotter ward regarding the management of skin integrity and pressure area care and hydration. We saw fluid balance charts that were incomplete and gaps of up to 6 hours in the recording of repositioning patients at risk of developing pressure ulcers.

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

17 February 2026

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Briefing M10

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3 March 2026*
Agenda item number	*9.3*
Report title	*Finance Briefing M10*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Information
Accountable Director	*Paul Antunes Goncalves* *Group Chief Financial Officer*
Author(s)	*Finance Team*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*Content discussed at Finance and Performance Committee*
Financial implications, if applicable	*None*
Action / decision required	*The board is asked to:* • *Note the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions.* • *Note the three key areas of internal focus – delivery of our variable income, delivery of our efficiency target and workforce controls (bank and agency).* • *Note the forecast risk that is being mitigated through internal and external actions.*

Assurance Rating Key:

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

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

Executive Summary

Trust Board is asked to note the following:

- 2025/26 Revenue position M10 YTD (Year to date)

The Group delivered a £8.4m deficit (£2.6m adverse than planned).

- 2025/26 Capital position M10 YTD

The Group delivered capital expenditure of £44.1m (£28.7m lower than planned).

- 2025/26 CIP position M10 YTD

The Group delivered savings of £56.4m (£4.2m lower than planned).

- M10 Cash position

The Group ended the month with a cash balance of £18.8m (£18.2m lower than planned).

Lincolnshire Community and Hospitals NHS Group
Trust Board – 3 March 2026
Finance Briefing M10

Executive Summary

At month 10 the year-to-date position for the Group is an £8.4m deficit, £2.6m adverse to plan. The Group have delivered actual surplus positions between month 7 and 10, however the plan required a further improvement. This deficit position was mainly built in quarter 1, with quarter 2 and 3 seeing an improvement in our monthly run rate. The Group is required to increase our savings as we progress through the year which will return the Group to financial balance by 31 March 2026.

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

As outlined previously the financial position is challenging, however the risk position is reducing. The Group are confident that through internal and external actions we will be able to deliver our breakeven year end position.

Our capital spend is behind our planned level, mainly driven by delays in approval, it is anticipated that this will be recovered by the end of the financial year. Mitigation options are being developed to ensure that all capital is utilised by 31 March, this will be spent on scheme that support our strategic direction and improve our working environment (e.g. equipment). To support delivery delegated authority by the Board has been received that enables decision making to shortened with retrospective approval to Board.

The cash position is £18.2m behind plan, with a cash balance at the end of month 10 of £18.2m. The Group are in the process of drawing down our remaining 25/26 capital cash which will improve the cash position. Our cash position is monitored daily, and this continues to be a key area of focus in our Finance and Performance Committee.

Summary Position

Month 10 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)	2.4	0.5	(1.9)	0.6	0.2	(0.5)	1.7	0.3	(1.4)
CIP Delivery	9.3	7.3	(1.9)	1.4	1.0	(0.4)	7.8	6.3	(1.6)
Capital Spend	12.4	7.0	(5.4)	0.0	0.1	0.1	12.4	6.9	(5.5)
Agency Spend	(1.0)	(1.1)	(0.1)	(0.1)	(0.0)	0.1	(0.9)	(1.1)	(0.2)
Cash Balance	(0.9)	(1.2)	(0.3)	0.8	(0.5)	(1.3)	(1.7)	(0.8)	1.0

Month 10 Position	Group performance			LCHS performance			ULTH performance		
	Year to Date			Year to Date			Year to Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(5.8)	(8.4)	(2.6)	(1.3)	(0.9)	0.4	(4.5)	(7.5)	(3.0)
CIP Delivery	60.6	56.4	(4.2)	6.6	7.4	0.7	54.0	49.1	(4.9)
Capital Spend	72.8	44.1	(28.7)	2.7	2.5	(0.2)	70.1	41.6	(28.5)
Agency Spend	(12.1)	(12.7)	(0.7)	(1.3)	(0.6)	0.8	(10.7)	(12.2)	(1.4)
Cash Balance	36.9	18.8	(18.2)	26.0	12.6	(13.4)	10.9	6.2	(4.8)

Revenue Position

The Group's year to date financial position is a £8.4m deficit at month 10, this position is £2.6m adverse to our planned position. The Group have seen run rate improvements and have delivered in month surplus positions since M7, however these have been below our planned level and required recovery plan actions. The revenue position requires further improvements in our run rate to delivery our breakeven position at the end of the year.

The Group have received funding to cover the impact of the Industrial Action by our resident doctors, this impacted our activity/income (reduced) and increased our costs (backfill costs); as at end of February, there is no further dates of industrial action.

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

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

2. **Delivery of our efficiency target** – Our efficiency plan is slightly (£4.2m) behind plan, some schemes have not delivered as intended and mitigations are being developed. Additional assurance meetings have taken place with our care groups to develop mitigations and ensure forecast scheme are on track for delivery. The position includes recovery actions to support the year end position, however a number of these actions are non recurrent/one-off in nature. This position is a key area of focus and is reported weekly to executive colleagues.

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

The Group are working constructively with external partners to support in year delivery, this includes our ICB and our regional colleagues.

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

The Group have undertaken a detailed review of the forecast position; the position has been derisked with £9.3m of risk identified mainly due to shortfalls in our efficiency systems.

Internal and external mitigations have been developed and implemented, and the Group are confident that we will be able to deliver our breakeven year end position.

Capital Position

The Group has the largest ever capital programme of £129.1m (small increase since last update due to additional allocations received in ULTH), key schemes including Community Diagnostic Centre at Boston, first year of our ePR, new ED department at Pilgrim Hospital and Endoscopy improvements.

At month 10 the Group were £28.7m behind our capital plan, this was driven by delays on approvals for our ePR and Community Diagnostic Centre. These have now been received, and progress is underway.

Significant capital spend is planned in the remaining two months of the financial year and the Group are confident of utilising all capital funds available in year and additional mitigation options have been developed if schemes are delayed further. All mitigation options are in line with our strategic direction of travel and improve our working environment (e.g. equipment).

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

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	*3 March 2026*
Agenda item number	*9.3*

Finance and Performance Committee Upward Report of the meeting held on 23 January 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:	03 March 2026
Report from:	Finance and Performance Committee
Report from meeting held on:	23 January 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 23 January 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) Operational Performance
b) PRM Upward Report
c) Patient Services Hub Update

In relation to Cancer performance, though the trajectory remained below plan, the Group slightly improved its month-on-month performance against the national 28-day, 31-day and 62-day standards in November 2025. 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.

Performance against the Diagnostics Waiting Times and Activity (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 Urgent and Emergency Care, 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.

The Patient Services Hub staff consultation, which commenced in November 2025, was completed in January 2026. Steps were being taken to collate all the feedback received with a plan to respond to them at the beginning of February 2026.

Another step implemented was the commissioning of the PWC to support the Patient Services Hub delivery. The vision was to establish a Patient Service Hub which provides a scaled Care Coordination service to deliver seamless, end-to-end patient pathways across the Lincolnshire system.

Assurances in respect of Objective 1c:

a) Finance Report including CIP, Capital, CRIG and Productivity, Improvement and Transformation Oversight Forum (PITOF) upward report (December 2025)
b) Annual Plan (Operational & Financial) including Cost Improvement Programme (CIP)
c) Costing & Benchmarking Report (Q2)
d) Post Investment Evaluation
e) Contract Award Reports
f) Data Quality Assurance Framework – draft approach

The Group 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.

The Cost Improvement Programme (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 Group CIP schemes.

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.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update
b) Emergency Planning Group Upward Report

The review of Planned Preventative Maintenance (PPM) remained on target for completion in January 2026.

For the 2025 Annual Assessment of Core Standards for Emergency Preparedness, Resilience, and Response (EPRR), both ULTH and LCHS have been assessed as 'substantially compliant' with the core standards by NHSE and the ICB.

Assurances in respect of other areas:

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

The Committee received and considered a suite of performance reports.

The Committee received and noted the position in respect of the Board Assurance Framework, Risk Register, policy position 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) 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
23 January 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	*3 March 2026*
Agenda item number	*9.3*

Finance and Performance Committee Upward Report of the meeting held on 19 February 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:	03 March 2026
Report from:	Finance and Performance Committee
Report from meeting held on:	19 February 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 19 February 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) Operational Performance
b) PRM Upward Report

In relation to Cancer performance, all 3 Cancer standards, the 28-day, 31-day and 62-day standards, were below plan and have deteriorated from a strong November 2026 position. The performance report noted that the Groups Cancer performance was not an outlier but reflected the national picture in December 2026.

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.

Performance against the Diagnostics Waiting Times and Activity (DM01) standard declined further December 2026 due to capacity shortfalls in the Audiology, Non-Obstetric Ultrasound (NOUS) and Magnetic resonance imaging (MRI) services. Work is underway to improve the capacities of these services.

In relation to Urgent and Emergency Care, 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.

Ambulance Handover: In relation to the 45 Minute Handover standard, the year-to-date Group 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%.

Assurances in respect of Objective 1c:

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

The Group delivered an actual year-to-date deficit of £8.4m deficit which was £2.6m adverse to plan. The in-month position was at £0.5m surplus which was £1.9m adverse to plan.

The Cost Improvement Programme (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 CIP schemes.

The February 2026 PITOF meeting was stood down due to a lack of quoracy. The report was a synopsis of the reports which would have been reviewed had the meeting not been stood down.

The Committee noted from the report that the Group was in a transitional period between the current PITOF work programme and the 2026/27 transformational programme. Work was also being undertaken to strengthen the PITOF framework.

Assurances in respect of Objective 1d:

a) Estates and Facilities Update
b) Transfer of Assets from NHS Property Services

Recent Fire and Rescue Service audits returned broadly compliant outcomes.

The Committee was informed that the car parking development work is progressing for 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 Planned Preventative Maintenance (PPM) Audit undertaken in January 2026 has been received and was undergoing a detailed review and factual accuracy ahead of the final document.

Assurances in respect of other areas:

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

The Committee received and considered a suite of performance reports.

The Committee received and noted the position in respect of the Board Assurance Framework, Risk Register, policy position 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) 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
19 February 2026

People Committee Upward Report

Caring and building a
healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*03 March 2026*
Agenda item number	*10.1*

People Committee Upward Report of the meeting held on 13 January 2026

Accountable Director	*Claire Low, Group Chief People Officer*
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 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:	13 January 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 13 January 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) Education Oversight Group Upward Report
b) Safer Staffing Nursing (including AHP compliance)
c) Safer Staffing Medical
d) National Nursing Job Profiles

The Education Oversight Group offered assurance to the Committee with positive positions noted for both organisations within the Group at the end of November 2025 - core learning compliance was above the 90% KPI target. LCHS was at 95.79%, which exceeded target and showed a slight increase on the position in October 2025, while was at 91.95% compliance which was also above target but represented a slight decrease against the position in October 2025.

In the month of November 2025, a total of 80 Apprentices commenced their programmes across the Group.

The monthly sickness rate for the Group increased slightly in November 2025 to 8.1%, from 8.01% in October 2025.

The Committee noted that the content of the Medical Safer Staffing Report had significantly improved over time to the required quality in November 2025.

The Committee noted the steps being taken to progress the National Nursing

Job Profiles Action Plan 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. 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.

Assurances in respect of Objectives 2b:

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

The Workshop Strategy Group reported that in November 2025, ULTH remained in the top 1st and 2nd percentile with 87% of their Health Roster metrics compared to other Acute Trusts. In November 2025, LCHS remained in the 1st and 2nd percentile for 60% of their Health Roster metrics compared to other Community Trusts.

In November 2025 the Group remained off plan against the 2025/26 Workforce Plan, mainly due to ULHT's high spend on bank staffing. Recovery actions include the implementation of bank spend controls, and steps in 2026/27 and 2028/2029 to reduce sickness absence rates. The Committee noted position on against the Workforce Plan and the improvement actions being implemented or planned for implementation in the future.

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 noted 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).

Assurances in respect of Objectives 2c:

a) Culture and Leadership Group Upward Report
b) Gender Pay Gap Annual Report
c) Ethnicity Pay Gap Annual Report
d) Pay Gap Action Plan
e) NMC Quarterly Report

The Culture and Leadership Group Upward Report noted that the Group's Leadership Pathways Programme had been launched. The Leadership Hub aspect of the Programme had gone live, with the Leading with Behavioural Intelligence aspect of the Programme being in the pilot stage. Elements of the People Management Essentials aspect of the Programme are still being reviewed and finalised by subject matter experts.

The Committee received the Gender Pay Gap and Ethnicity Pay Gap Annual Reports, and the Pay Gap Action Plan. The Committee noted that both pay gaps were not equal pay issues because the Trust adheres to national NHS job evaluation schemes ensuring equal pay for equal work. All Variations reflect workforce composition, structural changes, and national policy changes such as National Clinical Impact Award (NCIA)/National Clinical Excellence Awards (CEAs).

During Quarter 3, 44 professional concerns continued to be managed/ monitored within the Group.

The Committee received an update on the work undertaken across the Group to support the 'Reward and Recognition Programme'

Assurances in respect of Objectives 2d:

a) Reward and Recognition Update

The Committee received an update on the work undertaken across the Group to support the 'Reward and Recognition Programme'

Assurances in respect of other areas:

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

The Committee received a Staff Story which focused on the Group's commitment to supporting employees who are affected in any way by the menopause and educating and supporting managers so that employees reporting issues are treated fairly and given appropriate support.

The Committee reviewed the Risk Register, including all the high risks and the emerging risks that had been allocated to the People Committee.

The policy position was noted with the positive effect the extension of the policies by 6-months have had. The Committee also noted that, this 6-month extension was in support of the work to develop the Group's policy documents and did not in any way impact on the validity of the policy.

The Committee reviewed the work being undertaken to ensure the work to progress outstanding Internal Audit recommendations were correctly recorded by the Internal Auditors.

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 concern about the capacity of the job evaluation team to undertake the National Nursing Job Profiles Project.

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;

Jim Connolly, People Committee Chair (Acting)

13 January 2026

People Committee Upward Report

Caring and building a
healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*03 March 2026*
Agenda item number	*10.1*

People Committee Upward Report of the meeting held on 10 February 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 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 February 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 February 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 – Executive Scoreboard
b) Education Oversight Group Upward Report
c) People Directorate Capacity Upward Report
d) Safer Staffing Nursing (including AHP compliance)
e) Safer Staffing Medical

The Committee Performance Dashboard Report stated that the sickness rate at ULTH in January 2026 was at 5.43% against a Q4 Target of 4.50%, while the sickness rate at LCHS was at 6.80%in December 2025 against a Q3 target of 4.96%.

The ULTH vacancy rate for January 2026 was at 6.50% against a Q4 Target of 10.60% which was the expected position as the largescale organisational change programmes progress and vacancies are being held/deferred as opportunities for staff who may be displaced by the programmes. The vacancy rate at LCHS was at 9.84% against a Q4 Target of 10.00%. Again, this was the expected position as the largescale organisational change programmes progress and vacancies are being held/deferred as opportunities for staff who may be displaced by the programmes.

The Education Oversight Group offered assurance to the Committee with positive positions noted for both organisations within the Group at the end of December 2025 - core learning compliance remained above the 90% KPI

target. LCHS was at 95.91%, which exceeded target and showed a slight improvement on the position in November 2025. ULHT was at 92.97% compliance which was also above target and represented a slight improvement on the position in November 2025.

In the month of December 2025, 15 new staff members registered to be part of the Student Nursing Associate Apprenticeship Programme which commences in February 2026. The Committee was informed that the Group had a target of 40 Student Nursing Associate Apprentices registering be part of the Student Nursing Associate Apprenticeship Programme.

The Committee endorsed the People Directorate's proposed prioritisation initiative, which has been developed to ensure that the Directorate is able to align its capacity with organisational priorities and the significant programmes of work currently underway. The Committee also supported the consistent and coherent communication of these priorities to stakeholders, and to agree the proposed review arrangements for paused activity so that this work can be reactivated as organisational capacity increases.

The Committee was assured the though the work on the Group Benefits Alignment has been paused, the full alignment will be delivered in 2026/27. It was noted that a number of benefits had already been aligned and offers will not be reduced or withdrawn.

The Committee was provided with a reasonable level of assurance regarding nursing safer staffing for the Group in December 2025. The report 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 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 report noted that as more Band 5 registrants become eligible for progression within the mandated 12 – 24-month window, services will need to rebalance Band 5/Band 6 establishments. This may create upward pressure on staffing budgets but also presents a strategic opportunity to strengthen clinical leadership, capability and retention.

The Committee was provided reasonable assurance with regards to the medical current staffing numbers for the Group in December 2025.

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report
b) Workforce Hub Upward Report
c) Guardian of Safe Working
d) Patient Services Hub

The Workshop Strategy Group reported that in December 2025, workforce performance remained stable with the metrics relating to vacancy, turnover, and mandatory training performance continuing to meet expected levels. The Committee was informed that though sickness absence increased within LCHS, safe staffing has been maintained across all services in the Group.

The Workforce Hub report informed the Committee that the Group remained off-plan against the 2025/26 Workforce Plan due to a combination of factors including substantive recruitment, TUPE activity, lower-than-expected Mutually Agreed Resignation Scheme (MARS) leavers, and reduced turnover across the Group. Year-end forecasts indicate an FTE reduction delivery of 401.76 FTE (or 474.85 FTE including income-backed roles) against the target of 665 FTE.

The report noted that the actions to recover the position and return to plan included tighter bank spend controls, targeted recruitment in critical roles, enhanced job planning, rostering improvements, and the implementation of a Priority Access Bank Rate.
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. 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 on 22 January 2026.

The Guardian of Safe Working submitted a report which covered the period from 01 October 2025 to 31 December 2025. The report assured the Committee that patients received safe, high-quality care, and that Resident Doctors in training and Locally Employed Doctors at ULHT had worked as was required by their contracts over the period.

Assurances in respect of Objectives 2c:

a) Equality, Diversion and Inclusion Group
b) Culture and Leadership Group Upward Report
c) Employee Exclusions

The Equality, Diversion and Inclusion (EDI) Upward Report provided the Committee with significant assurance about the progress of the EDI agenda in the Group.

Additionally, the report informed the Committee that EDI objectives have now been fully embedded into Group Board appraisals, which completes a long-standing requirement within both HIA and 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.

The report stated that in line with national requirements, the Group Board has undertaken a review of anti-discrimination approaches, including a planned relaunch of the United Against All Forms of Discrimination campaign.

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 recently shared with the Group Board's People Committee.
The Committee was assured that in relation to the 2025/26 winter vaccination campaign, the vaccination rates are 55.8% for LCHS and 56.58% for ULHT. This represented a significant improvement for ULHT compared to the vaccination rate of 35% for 2024/25.

Assurances in respect of other areas:

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

The Committee 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.

The Committee reviewed the Risk Register, including all the high risks and the emerging risks that had been allocated to the People Committee.

The Committee reviewed the work being undertaken to ensure the work to progress outstanding Internal Audit recommendations were correctly recorded by the Internal Auditors.

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

6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

Vicki Wells, People Committee Chair

10 February 2026

NHS
Lincolnshire Community and Hospitals NHS Group

Ethnicity and Gender Pay Gap Reports
United Lincolnshire Teaching Hospitals NHS Trust

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3rd March 2026*
Agenda item number	*10.2*
Report title	*Ethnicity and Gender Pay Gap Reports United Lincolnshire Teaching Hospitals NHS Trust*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Approval* • *Assurance* • *Information*
Accountable Director	*Claire Low, Chief People Officer*
Author(s)	*Michael Du Rose, Associated Director of People*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial Assurance*
Prior approval process, if applicable	*EDI Group – November 2025* *People Committee – 13th January 2026*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *Consider the information contained within this report.* • *Approve for publication on the Trust's website.*

Assurance Rating Key:

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	

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

Executive Summary

In line with national guidelines, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) reports Gender Pay Gap data based on the snapshot date of 31st March 2025. ULTH is part of a group arrangement with Lincolnshire Community Health Services NHS Trust (LCHS), together forming the Lincolnshire Community and Hospitals NHS Group (LCHG). While the Board and senior leadership team operate as one, individuals remain employed by their original organisations. This structural arrangement impacts reporting, particularly at senior levels, and should be considered when interpreting the data.

For the Gender Pay Gap, women earn £0.87 for every £1.00 earned by men based on median hourly pay. This represents a median gender pay gap of 12.6%, an improvement from 14.2% last year and 14.6% the year before. Women's mean hourly pay is 27.6% lower than men's, which is slightly worse than last year's 27.2% gap but better than 29.3% two years ago. Bonus payments relating to the Clinical Excellence Awards (CEA) show women receiving £0.51 for every £1.00 men receive. National changes to the CEA scheme mean only legacy 2018 awards are still paid, which has caused a discrepancy. Women hold 79.6% of the lowest-paid jobs, a decrease from 81.7% last year, and 61.6% of the highest-paid jobs, decreased from 63.8% last year. Women hold 80.2% of lower middle-paid jobs and 81.4% of upper middle-paid jobs. While there is steady progression through the middle quartiles, the decline in the top quartile is disappointing, however this is likely to be impacted by the group structure arrangements. ULTH now has nine years of Gender Pay Gap data, showing slow improvement: the median gap has reduced by 1.5% and the mean gap by 5.2% since 2017. The national median gender pay gap is currently 13.1%, compared to ULTH's 12.6% in 2025.

For the Ethnicity Pay Gap, White colleagues earn £0.82 for every £1.00 earned by Black and Minority Ethnic (BME) colleagues and the same compared to colleagues whose ethnicity is unknown. The median ethnicity pay gap is 18.24%, meaning White colleagues earn 18.24% less than BME colleagues, and 18.36% less than those whose ethnicity is unknown. This represents an improving trend compared to last year's figures of 19.47% and 19.45% respectively. The mean ethnicity pay gap is 33%, with White colleagues earning 33% less than BME colleagues and 37% less than those whose ethnicity is unknown. Last year's figures were 32% and 38% respectively.

These gaps are influenced by workforce structure and representation in higher pay quartiles, particularly medical and dental roles. Asian and Black colleagues hold 27.9% of the highest-paid jobs compared to 24.2% last year, while White British colleagues hold 58% of the highest-paid jobs compared to 62.2% last year. In contrast, White colleagues hold 85% of the lowest-paid jobs. The ULTH workforce comprises 30% BME colleagues, 69% White, and 1% unknown. Bonus payments, defined as Clinical Excellence Awards (CEAs), show a gap in favour of White consultants, with 30.2% of White consultants receiving a CEA compared to 21.6% of BME consultants and 14.8% of those whose ethnicity is unknown. National changes to the CEA scheme mean only legacy 2018 awards are still paid.

It is important to note that both the gender and ethnicity pay gaps are not equal pay issues. The Trust adheres to national NHS job evaluation schemes to ensure equal pay for equal

work. Variations reflect workforce composition, structural changes, and national policy changes such as CEAs.

In summary, the Trust has seen small improvements in both gender and ethnicity pay gaps, although progress remains slow. The ethnicity pay gap continues to be influenced by the concentration of BME colleagues in higher-paid medical roles, while the gender pay gap reflects persistent underrepresentation of women in the highest pay quartile. The Trust will continue to monitor these gaps, undertake targeted workforce development, and maintain transparency in reporting.

These reports have previously been approved by the People Committee on 13th January 2026. The Board is asked to approve the reports, for publication on the Trust's website by the statutory deadline of 31st March 2026.

NHS
United Lincolnshire Teaching Hospitals
NHS Trust

United Lincolnshire Teaching Hospitals NHS Trust Gender Pay Gap Report 2025-2026

Caring and building a healthier future for all

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Executive Summary

In line with national guidelines, when reporting Gender Pay Gap data, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) is working on the data as at the previous 31st March. This means the snapshot date for data in this report is 31 March 2025.

It should be noted that United Lincolnshire Teaching Hospitals NHS Trust (ULTH) is in a group arrangement with Lincolnshire Community Health Services NHS Trust (LCHS) – together known as Lincolnshire Community and Hospitals NHS Group (LCHG). The Board and senior leadership team have come together as one single team, however, individuals remain employed by their original organisations. This means that those individuals in senior leadership positions will be reported within separate organisational data and therefore this has impacted on the reporting data which is not wholly representative of the actual workforce, particularly at the more senior bands.

In ULTH, women earn £0.87 for every £1 that men earn, when comparing median hourly pay. This is a small improvement on last year's data (£0.86 for every £1), and £0.85 in the previous year.

The median is the generally accepted main indicator across all organisations who take part in Gender Pay Gap reporting. The Trust's median gender pay gap is 12.6% in 2025, compared to 14.2% in 2024 and 14.6% in 2023.

For women who receive a bonus, they received £0.51 for every £1 men received. In an NHS Acute Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce. Changes nationally mean that only consultants on the previous (2018) scheme now still receive a bonus.

It is important to note that the Government's Gender Pay Gap portal incorrectly calculates the Trust's bonus pay gap, as it assumes that all of the workforce is on the same terms and conditions and therefore the whole workforce is eligible for a bonus. This is not the case for NHS employees. Our narrative here acknowledges this, and our data reported in this report represents the true picture: percentage of those eligible for a bonus – i.e. Consultants on Medical and Dental terms and conditions - versus percentage of those from that part of the workforce receiving a bonus.

At this Trust, women hold 79.6% of the lowest paid jobs (the figure was 81.7% last year, and 83.5% the year before). Women hold 61.6% of the highest paid jobs, compared to 63.8% last year, and 63.7% the year before.

There has been a decrease of 2.1% in the number of women holding the lowest paid jobs, which is an improving trend in the context of the gender pay gap. However, in the same year, disappointingly there has been a decline of 2.2% in the number of women holding the highest paid jobs.

These fluctuations may reflect the changes at the highest-paid level of the organisation, with a newly formed LCHG Group Executive and Senior Leadership team during the last year, with some members of this team being employed by the partner organisation (LCHS).

Women hold 80.2% of the lower middle-paid jobs (81% last year) and 81.4% of the upper-middle paid jobs (79.8% last year). The overall picture is one of slow progression steadily upwards through the lower to middle and upper-middle pay quartiles for women, but also with the disappointing decrease in the top pay quartile in this reporting period.

When comparing mean (average) hourly pay, women's mean hourly pay is 27.6% lower than men's. This is a slight worsening of the position (0.4%) compared to last year's data of 27.2% lower-paid, whereas the year before that it was even lower, with a 29.3% gap in pay between men and women, based on the mean.

ULTH now has nine years' worth of data, since Gender Pay Gap reporting was introduced in 2017. The opportunity is taken in this report to indicate trends in that data. The headline is that, since reporting was made a statutory requirement in 2017, both the median and mean pay gaps are very slowly getting smaller, by just 1.5% in nine years for the most reliable measure (median) and 5.2% for the less-reliable average (mean).

The national Gender Pay Gap in the UK, on current available data (2024) is 13.1% (median) compared to the Trust's 14.2% gap in 2024. However, the median gap for the Trust based on the most recent data (2025) has improved to 12.6%, and when the latest national Gender Pay Gap data is published, like-for-like comparison will be possible.

It is important to note that the gender pay gap is not the same as an equal pay gap, i.e. men being paid more than women for doing the same job (or vice-versa) which would be unlawful. The Trust follows the national NHS job evaluation schemes to ensure equal pay for equal work.

Background

Whilst the two constituent trusts of the Lincolnshire Community and Hospitals Group (LCHG) each have a statutory duty to report on their gender pay gaps in their own right, a Group Gender Pay Gap action plan has been developed, and further analysis of the data as a Group has been undertaken in preparing this.

Employers with 250 or more employees have been required to publish information on the pay gap between male and female employees since 31 March 2017, under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which can be found at The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (legislation.gov.uk)

Organisations in the public sector, such as NHS Trusts, are required to report on the gov.uk Gender Pay Gap website (Search and compare gender pay gap data - Gender pay gap service - GOV.UK), against a set of six key indicators, based on data from 31 March each previous year, for example, the “snapshot date” for this report is 31st March 2025. Organisations are then required to publish the data and a narrative (“Gender Pay Gap Report”) so that employees and members of the public can access the data and report, along with an action plan to address disparities, by 31 March each year, for example, this report is to be published on the Trust’s website by 31 March 2026 (Gender pay gap reporting - United Lincolnshire Hospitals).

Private sector employers with 250 or more employees are also required to publish Gender Pay Gap information, albeit with a slightly later publication date of 5th April each year.

In preparing this report, the author has consulted and followed the NHS Employers Gender Pay Gap guide: Addressing-your-gender-pay-gap-guide.pdf (nhsemployers.org) which was co-produced with the Health and Care Women Leaders Network.

Understanding the Gender Pay Gap Calculations

The six key indicators that the Trust is required to report on are:

1. percentage of men and women in each hourly pay quarter (lower, lower middle, upper middle and upper quartile) by number of employees.
2. mean (average) gender pay gap using hourly pay.
3. median gender pay gap using hourly pay.
4. percentage of men and women receiving bonus pay.
5. mean (average) gender pay gap using bonus pay.
6. median gender pay gap using bonus pay.

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes: basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework.

Pay does not include overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of a vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the Clinical Excellence Awards (CEAs) to consultants, following the NHS Employers Gender Pay Gap Guide.

What does median mean?

This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the ‘typical’ situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all gender pay gap issues will be picked up. They could also fail to

pick up as effectively where the gender pay gap issues are most pronounced in the lowest paid or highest paid employees.

What is the meaning of mean?

The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure, which is why the median is used as the headline figure in gender pay gap reporting.

About our results

The Trust's Gender Pay Gap has been on a generally decreasing (i.e. improving) trend since reporting began, in line with the national trend both inside and outside of the NHS.

The data sets on which the Trust's Gender Pay Gap report for the current reporting cycle are based can be viewed in appendix 1.

Since reporting was made a statutory requirement in 2017, the median pay gap is very slowly getting smaller, by just 1.5% in nine years for this, the most reliable measure. The improvement since reporting began for the less-reliable average (mean) is 5.2%.

The trend data from 2017 for the median hourly rate and the average hourly rate (mean) are noted as follows:

Reporting Year	Median Hourly Rate Gap	Average (Mean) Hourly Rate Gap
2017-2018	14.1%	32.8%
2018-2019	15.2%	32.8%
2019-2020	15.3%	31.6%
2020-2021	16.8%	31.4%
2021-2022	14.6%	28.6%
2022-2023	16.8%	29.3%
2023-2024	14.6%	29.3%
2024-2025	14.2%	27.2%
2025-2026 (current)	12.6%	27.6%

A trend chart for the Median Hourly Rate and the Average Hourly Rate (mean) is included in appendix 2.

As with previous years, the main driver of the Trust's gender pay gap remains the structure of the NHS workforce, with female colleagues comprising the majority of the lower paid roles and majority of the male colleagues in the Trust occupying higher paid roles, including the medical workforce (especially consultant medical staff) and Very Senior Manager (VSM) roles.

For this reason, further analysis on the gender pay gap has been undertaken to identify the Agenda for Change gender pay gap and the Medical and Dental gender pay gap. Please note that this information is only available as the mean rather than the median.

Overall, the mean Gender Pay Gap for all colleagues on Agenda for Change terms and conditions of employment is small, at £296.79 per year and a percentage gap of 0.56% overall (Bands 1/Apprentice to Band 9 inclusive). This does not include those on Very Senior Manager (VSM) contracts and Executive Directors, to avoid distortion from higher salaries.

To assist further, each band has been analysed. This does reveal a couple of "hotspots" which would benefit from further analysis as indicated in the table below:

Agenda for Change

Band	Difference in Mean Salary	Pay Gap % (Mean)
Band 8b	-£957.77	1.4% lower for women
Band 8c	-£2,156.94	2.61% lower for women
Band 8d	-£4,472.23	4.53% lower for women
Very Senior Manager	+£3,616.67	2.64 lower for men
Executive Director	-£27,362.93	14.42 lower for women

Further investigation, as captured in the action plan, will establish the reasons for the difference at these bands and whether they are explained by the Agenda for Change pay structure, and in particular any length of service-related differences which are objectively justifiable. The Very Senior Manager (VSM) and Executive Director gaps may also benefit from further enquiries, to establish whether the differences there are also objectively justifiable.

Medical and Dental

This Trust has a large medical workforce, employing 417 Full-Time Equivalent (FTE) female doctors, and 742 FTE male doctors. The overall gender pay gap for the medical and dental workforce is +5.4% (mean). This means that overall, the female medical workforce is paid more than men, not including any bonus (CEA for Consultants) pay.

As with all averages, in a small workforce a significantly higher or lower salary can distort the outcome substantially. An example of this can be seen in the large gender pay gap for men at GPCA/Hospital Practitioner grade, which is a very small workforce of 1.73 FTE.

Band	**Difference in Mean Salary**	**Pay Gap % (Mean)**
Specialty Doctor	-£6, 414.66	Women earn 7.18% less
GPCA/Hospital Practitioner	+£11,786.03	Men earn 13.7% less

As with the Agenda for Change Workforce, a couple of hotspots, highlighted in the table above, have been identified as warranting further investigation, particularly to establish the objective justification behind the substantial pay gap for women at Specialty Doctor grade, and this is therefore reflected in the action plan.

Gender Disparity – Pay Quartiles

79.6% of the workforce in the lowest pay quartile are female. This means that women hold 79.6% of the lowest paid jobs. In comparison, 61.6 % of the workforce in the top pay quartile are women. This means that women hold 61.6% of the highest paid jobs, which is disproportionately low considering their representation throughout the lower and upper middle quartiles (around 80-81%). Also of note, the percentage of women in the top pay quartile has decreased by 2.2% over the last year.

Further detail relating to the pay quartiles can be located in appendix 1.

Gender Disparity – Mean Salary

The data in Appendix 1 highlights that below Band 8A Agenda for Change (AfC), women are likely to be paid more than men. The reasons why female colleagues are more highly paid in some of the pay bandings is likely to relate to factors like length of time in post, career progression and seniority in the nursing and midwifery workforce.

However, from AfC Bands 8B through to Band 8D inclusive, similar to the previous year, men are paid more than women, with the most significant gaps in monetary amounts occurring throughout these bands. The reasons for this are not evident from the gender pay gap data on the face of it but may relate to length of service and associated gaining of higher increments. It is a narrowing gap, and in previous years the disparity started earlier at Band 8A and continued into Band 9, which suggests that the gap may be related to increments and time-served. Further analysis as a Gender Pay Gap action will confirm. This would then inform further action if the difference cannot be objectively justified.

The NHS EDI Improvement Plan asks all Trusts, as part of High Impact Action 3, to consider the gender pay gap for the medical workforce and ensure that the “Mend the Gap” report recommendations are implemented at the Trust (NHS EDI Improvement Plan, High Impact Action 3). Overall, across the medical workforce, women earn +5.44% more than men.

Gender Disparity – Bonus Pay

Bonus pay relates to the CEAs which only apply to members of the consultant workforce.

Historically, CEAs were an area where gender disparity was evident. In recent years the Trust has transformed its approach to CEAs by ensuring a gender balance on the awarding panel and taking steps to encourage applications from female consultants for the CEAs and has distributed awards equally in the current reporting cycle. Equity was achieved in previous years, in that for every £1 that a male consultant received, a female consultant received the same amount.

Bonus pay relates to the CEAs which only apply to members of the consultant workforce. Due to the national changes, in reality this now applies to an even smaller group, those who were already receiving a CEA as of 2018.

Mean & median bonus

Gender	Avg. Pay	Median Pay
Male	£9,841.42	£6,032.04
Female	£5,400.40	£3,079.40
Difference	£4,441.02	£2,952.65
Pay Gap %	45.1	48.9

For every £1.00 that a male consultant receives in bonus, a female consultant receives £0.51. Last reporting year, there was no gender disparity with bonus pay within the Trust due to the steps taken by the Trust to ensure equity. However, due to the cessation of the CEA scheme nationally, new CEA bonuses are no longer paid and therefore only legacy (2018) CEAs are paid.

This inequity is enshrined in the national CEA agreement. It will lessen over time with retirements and other natural attrition, but the gap will close more quickly if more equitable arrangements can be agreed nationally.

How we will make progress to close the gap

It has been identified where the Trust needs to take action which will be taken forward within the context of the overall LCHG strategic objectives, the LCHG EDI Objectives 2025-2026 and the NHS EDI Improvement Plan.

The Gender Pay Gap action plan will be developed as an LCHG Group Action Plan this year and will be discussed further with key stakeholders such as the Women's Staff Network and Men's Staff Network. It will also take account of the Ethnicity Pay Gap reports and resulting actions, to be discussed further with the Race, Ethnicity and Cultural Heritage network (RE&CH) and the CODE Staff Network.

Disability Pay Gap reporting is also a requirement of the NHS EDI Improvement Plan, with Trusts required to implement an improvement plan to analyse the data and identify any improvements required now (2025) and by other protected characteristics by 2026.

Themes identified as areas for action in both Gender and Race Pay data are:

- Inclusive Recruitment – improvement of WRES 2 indicator (likelihood of job offer from shortlisting) through the inclusive recruitment project, working with the Inclusive Recruitment Champion, considering this from both a race and gender perspective.
- Explore declining trend of female leaders at middle and upper pay quartiles, identify root cause(s) and act accordingly.
- Work with the Talent Academy, Women's Network and Men's Network, to encourage more men into areas where they are underrepresented (i.e. at the lower pay quartiles) and continue to encourage women into occupations where they are under-represented, including science, technology, engineering and mathematics (STEM) roles.
- Progression as well as pay – develop a Group wide approach to talent management, which is strategic and inclusive, allowing for equitable rates of career progression.
- Continuing to apply pay rules fairly and consistently, and addressing any anomalies identified through further analysis of specific gaps identified in this report.

Gender Pay Gap Data on which this report is based

Appendix 1: – Data Tables 2025

Table 1. The mean and median hourly rates for males and females.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£26.82	£20.14
Female	£19.43	£17.60
Difference	£7.39	£2.54
Pay Gap %	27.6	12.6

Table 2. The proportion of male and female staff in each pay quartile.

Quartile	Female	Male	Female %	Male %
1	2074	530	79.6	20.4
2	2088	517	80.2	19.8
3	2092	477	81.4	18.6
4	1629	1016	61.6	38.4

Table 3. Mean salary for men and women within each Agenda for Change pay band or grade.

	Gender (Fte)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
Band 1 & Apprentice	15.93	9.99	£22,765.77	£19,942.69
Band 2	902.14	295.75	£23,615.00	£23,615.00
Band 3	1406.64	325.43	£25,015.33	£24,764.81
Band 4	442.19	130.19	£27,704.31	£27,675.38
Band 5	1769.73	320.86	£32,341.93	£32,173.87
Band 6	897.02	246.76	£40,785.71	£40,426.42
Band 7	544.52	128.03	£49,336.28	£49,265.50
Band 8A	232.95	84.71	£56,874.34	£56,703.00

Band 8B	72.73	31.69	£67,328.58	£68,286.35
Band 8C	25.02	11.00	£80,564.78	£82,721.73
Band 8D	9.00	9.80	£94,172.22	£98,644.45
Band 9	13.82	10.00	£113,799.36	£113,645.90
VSM	2.00	3.00	£136,925.00	£133,308.33
Exec Director	5.00	3.00	£162,378.40	£189,741.33

Table 4. Mean salary for men and women within each Medical Workforce pay band or grade.

	Gender (Fte)		**Mean Salary (£)**	
Pay Band/Grade	**Female**	**Male**	**Female**	**Male**
General Medical Practitioner	0.11		£125,033.12	
Consultant	99.49	287.95	£126,554.47	£126,748.87
Associate Specialist	1.65	17.54	£116,361.00	£115,434.42
Staff Grade		0.78		£87,867.00
Specialty Doctor	69.58	159.82	£79,158.57	£85,573.23
Specialist	1.87	1.00	£99,014.55	£100,784.00
GPCA/Hospital Practitioner	1.00	0.73	£85,895.00	£74,108.97
Specialty Registrar	111.46	154.01	£56,247.01	£56,002.07
Foundation Year 2	72.49	77.00	£42,008.00	£42,008.00
Foundation Year 1	58.84	43.00	£36,616.00	£36,616.00

Table 5. Mean and median bonus payments for males and females (Clinical Excellence Awards within the medical workforce consultant pay grade).

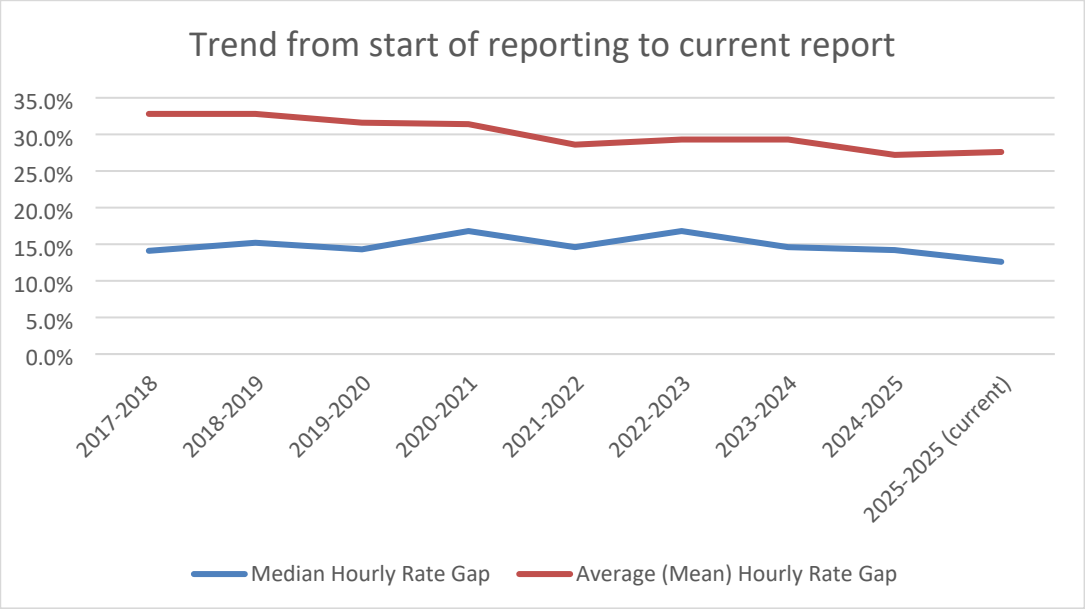
Gender	**Avg. Pay**	**Median Pay**
Male	£9,841.42	£6,032.04
Female	£5,400.40	£3,079.40
Difference	£4,441.02	£2,952.65
Pay Gap %	45.1	48.9

Table 6. Number of female and male medical staff receiving a bonus payment.

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	22	99.5	22.1
Male	70	288	24.3

NB: adjusted for relevant employee population (consultants on medical and dental terms and conditions), not total workforce headcount.

Appendix 2: – Trend Graph to 2025



NHS
United Lincolnshire Teaching Hospitals
NHS Trust

United Lincolnshire Teaching Hospitals Ethnicity Pay Gap Report 2025-2026

Caring and building a healthier future for all

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Ethnicity Pay Gap Report – United Lincolnshire Teaching Hospitals NHS Trust 2025-2026

1. Introduction

Unlike the Gender Pay Gap, there is no statutory requirement to report and act on Ethnicity Pay Gap data. However, for NHS organisations, there is a mandatory requirement through High Impact Action 3 of the NHS EDI Improvement Plan. This report is published in fulfilment of this mandatory duty and to seek to address any gaps identified through an agreed, co-produced action plan.

In line with national guidelines, when reporting Ethnicity Pay Gap data, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) is working on the data as at the previous 31st March. This means the snapshot date for data in this report is 31st March 2025. This is also aligned to the Gender Pay Gap snapshot date and reporting period.

There is no requirement for the ethnicity pay gap data to be uploaded to a gov.uk portal, unlike the gender pay gap data, as it is not a statutory requirement. However, the data in this report will be published on the Trust's website no later than end March 2026, following People Committee and Trust Board approval.

2. Executive Summary

It should be noted that United Lincolnshire Teaching Hospitals NHS Trust (ULHT) is in a group arrangement with Lincolnshire Community Health Services NHS Trust (LCHS) – together known as Lincolnshire Community and Hospitals NHS Group (LCHG). The Board and senior leadership team have come together as one single team, however, individuals remain employed by their original organisations. This means that those individuals in senior leadership positions will be reported within separate organisational data and therefore this has impacted on the reporting data which is not wholly representative of the actual workforce, particularly at the more senior bands.

In this Trust overall, White colleagues earn £0.82 for every £1.00 that Black and Minority Ethnic colleagues earn, based on median hourly rate. Likewise,

White colleagues earn £0.82p for every £1.00 that colleagues whose ethnicity is unknown earn.

The median is the generally accepted main indicator across all organisations who take part in pay gap reporting. The Trust has a median ethnicity pay gap of 18.24% overall, with White colleagues earning 18.24% less than Black and Minority Ethnic colleagues, and 18.36% less than those whose ethnicity is unknown. This is an improving trend compared to last year's ethnicity pay gap data, which was 19.47% and 19.45% respectively.

For the less reliable (but still reportable) Mean or Average, the ethnicity pay gap is 33%, with White colleagues earning 33% less than Black and Minority Ethnic colleagues, and 37% less than those whose ethnicity is unknown. Last year's ethnicity pay gap data reported 32% and 38% respectively.

It is essential to understand the structure of the workforce and the representation of Black and Minority Ethnic colleagues in the highest pay quartiles, particularly in medical and dental roles, and the influence that this has on the overall ethnicity pay gap at this Trust. At this Trust, Asian and Black colleagues hold 27.9% of the highest-paid jobs (the figure was 24.2% last year); whereas they only hold 7.3% of the lowest paid jobs (5.1% last year). White British colleagues hold 58% of the highest-paid jobs (62.2% last year), but 85% of the lowest-paid jobs (86.8% last year). 30% of the ULTH workforce identifies in ESR as Black, Asian and Minority Ethnic; 69% White and 1% unknown or not stated.

Further analysis beyond the data provided by the standard ESR ethnicity pay gap report has been undertaken because of these structural influences on the ethnicity pay gap. This report therefore contains an analysis by each band for Agenda for Change and Medical and Dental colleagues to allow for a more rounded picture of the ethnicity pay gap.

In an NHS Acute Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) and are only applicable to consultants in the medical workforce. Of those eligible for this bonus, 30.2% of White consultants received a CEA, 21.6% of BME consultants received a CEA, and 14.8% of those whose ethnicity is unknown/undeclared received a CEA.

There is therefore a bonus pay gap in favour of White consultants, which is examined further in this report, particularly in light of national changes to the CEA scheme which has now been discontinued and only legacy 2018 awards are still paid.

It is important to note that the ethnicity pay gap is not the same as an equal pay gap, e.g. White colleagues being paid more than BME colleagues for doing the same job (or vice-versa) which would be unlawful. The Trust follows the national NHS job evaluation schemes to ensure equal pay for equal work.

3. Methodology and Definitions

Whilst the two constituent trusts of the Lincolnshire Community and Hospitals Group (LCHG) each have a duty to report on their ethnicity pay gaps in their own right, a Group Ethnicity Pay Gap action plan has been developed, and further analysis of the data as a Group has been undertaken in preparing this.

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report. This national report unfortunately did not include ethnicity pay gap by band, which is essential to understanding an accurate picture.

For the purposes of these calculations, pay includes basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay and pay for piecework.

Pay does not include overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of a vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

What does median mean?

This is the difference between the hourly pay of the median white colleague and the hourly pay of the median black or minority ethnic colleague. The median for each is the person who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the ‘typical’ situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means

that not all ethnicity pay gap issues will be picked up. They could also fail to be picked up as effectively where the ethnicity pay gap issues are most pronounced in the lowest paid or highest paid employees.

What is the meaning of mean?

The mean ethnicity pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of white colleagues, and the mean hourly pay of black and minority ethnic colleagues. A mean involves adding up all the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure, which is why the median is used as the headline figure in ethnicity pay gap reporting.

Unfortunately, the median is not available for pay gap reporting by each band. The reporting by band based on the mean is already an additional step taken beyond the ESR standard BI report.

4. About our Results

At ULTH, the organisation-wide median ethnicity pay gap is 18.24% and the organisation-wide mean is 32.72%. This means that overall, the ethnicity pay gap exists for White colleagues as a whole group, i.e. earning less than Black or Minority Ethnic (BME) colleagues as a whole group.

The cause of this relates to how the workforce is structured (i.e. pay quartile distribution) and occupations which have attracted larger numbers of BME and internationally-educated colleagues with a large number of Asian colleagues at the highest paid bands (particularly in Medical and Dental roles) and a much lower number of BME colleagues at the lowest paid bands.

This is contrasted with a large number of White colleagues at the lowest paid bands, combined with a proportionally lower number of white colleagues in Medical and Dental roles.

Mean and Median Ethnicity Pay Gap

Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	£25.77	£19.55	2,809
Not Known	£26.67	£19.57	141
White	£19.42	£16.53	7,473
% Diff White - BME	-£32.72	-£18.24	62
% Diff White - Not Known	-£37.34	-£18.36	98
Median Pay Gap ULTH	**-18.24%**	**Mean Pay Gap ULTH**	**-32.72%**

Pay Quartile Distribution by Ethnicity Grouping

Quartile	Asian	Black	Mixed	Not Stated	Other	White British	White Other
1	130	59	25	14	19	2,203	154
2	522	146	33	43	55	1,613	193
3	633	145	41	35	72	1,534	109
4	589	148	54	49	138	1,541	126

Further breakdown by more-detailed ethnic origin groupings is available at Appendix 1. It is not possible to report here on each ethnic origin separately, because the majority of options within ESR have less than 11 colleagues selecting them, and often only 1 or 2 colleagues, which would lead to issues around confidentiality.

What is possible, and is indeed essential, is to report on and consider any pay gaps at each band, and within the Agenda for Change and Medical and Dental Workforce as a further step in understanding the overall, organisation-wide ethnicity pay gap accurately.

By Band – Agenda for Change

For colleagues working within the agenda for change bands 1 and apprentice to 9, the data shows significant pay gaps at Bands 5-7 for BME colleagues, and from Band 8a and 8b this is significantly better.

There is a large pay gap at B1/Apprentice which requires further exploration, however extensive work is carried out by the Talent Academy to attract and secure diverse new entrants to the workforce and this has been measured and recognised nationally as part of the Top 100 Apprentice Employer Awards, with the LCHG Talent Academy ranking in the Top 50.

The gaps at bands 3, 4, 5, 6 and 7 require further exploration to confirm if these are service-related and therefore objectively justifiable as part of applying Agenda for Change increments fairly and consistently, and any other legitimate factors.

A similar action is required for the “switchover” at Bands 8C to 9, where White colleagues begin to earn significantly less, which could be service-related or relating to a greater concentration of roles which attract legitimate allowances (for example, out-of-hours, on-call, unsocial hours payments etc.) held by BME colleagues. Until further analysis takes place, it is not yet possible to confirm this for certain.

In Appendix 2, it is also important to note progression gaps where there are proportionally low numbers of BME colleagues at that band. This is more pronounced in the LCHS data, contained in the separate LCHS Ethnicity Pay Gap Report, however it is a factor which requires attention across the whole Group.

The table below illustrates the gaps which require further exploration which are highlighted in yellow. The gaps from Band 8c where White colleagues are on average earning less than BME colleagues are highlighted additionally in turquoise.

ULTH – Gap by Workforce and Band Agenda for Change

Overall Mean Ethnicity Pay Gap AfC: 9.11% Banding	Diff White - BME Difference £	Diff White - BME Difference %
Band 1 & Apprentice	£6,421.65	28.88%
Band 2	£0.00	0.00%
Band 3	£582.29	2.32%
Band 4	£657.69	2.37%
Band 5	£2,229.68	6.65%
Band 6	£2,713.26	6.57%
Band 7	£1,671.60	3.38%
Band 8A	£471.52	0.83%
Band 8B	£371.15	0.55%
Band 8C	-£2,262.34	-2.79%
Band 8D	-£5,464.16	-5.68%
Band 9	-£7,866.31	-6.94%
VSM	-£11,368.75	-8.58%
Exec Director	£172,639.50	100.00%

A full breakdown is available at Appendix 2.

By Band – Medical and Dental

At ULTH, with its large medical and dental workforce compared to LCHS, there is a mean ethnicity pay gap of 11.82%, with BME colleagues earning less. This is to some extent structural, with Staff Grade and Specialist Doctors exclusively being Black, Asian or Minority Ethnic. There is also a very small number of colleagues working at GPCA/Hospital Practitioner Grade and the reasons for the pay gap need further analysis to confirm that the difference is service-related.

The ethnicity pay gap in the Medical and Dental workforce is also due to the 4.74% pay gap at Consultant grade, which is likely to be due to “time-served” and increments, with the more recent entrants to the Consultant workforce being predominantly Black, Asian or Minority Ethnic. This assumption should be checked and confirmed as an action arising from this report, using ethnicity and length of service data from ESR. The International Medical Graduate workforce is the “backbone” of medical services.

The ‘Mend the Gap’ pay report recommendations are also an action arising from this, as there is occupational “segregation” with only BME colleagues working at Specialist and Staff Grade, to ensure that they are able to access career progression opportunities fairly and in a timely way. Numbers of colleagues at these specific grades are now low, however at Specialty Doctor they are high and also to some extent at Associate Specialist grade.

It is positive to note that on entering the medical and dental workforce, there is still pay equity for White and BME colleagues at FY1 and FY2 grades, as there has been in previous reporting years. This is highlighted in **green** in the table below. The pay gap begins at Specialty Registrar grade (2.05% less mean salary for BME colleagues).

The table below illustrates and summarises these gaps. A full breakdown is available at Appendix 2. The gaps highlighted in yellow are those which are recommended to be explored further in the action plan. Those highlighted in green are where there are no difference in pay.

ULTH – Gap by Workforce and Band

Medical and Dental

Overall Mean Ethnicity Pay Gap Medical and Dental: 11.82%	Diff White - BME	Diff White - BME
Grade	Difference £	Difference %
General Medical Practitioner	£125,033.12	100.00%
Consultant	£6,212.01	4.74%
Associate Specialist	£866.08	0.74%
Staff Grade	-£87,867.00	-100.00%
Specialty Doctor	-£339.97	-0.41%
Specialist	-£99,630.22	-100.00%
GPCA/Hospital Practitioner	£15,956.39	18.56%
Specialty Registrar	£1,168.87	2.05%
Foundation Year 2	£0.00	0.00%
Foundation Year 1	£0.00	0.00%

Bonus pay gap (Clinical Excellence Awards)

In an NHS Acute Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce. Of those eligible for this bonus, 30.2% of White consultants received a CEA and 21.6% of BME consultants received a CEA, and 14.8% of those whose ethnicity is unknown/undeclared received one. There is therefore a bonus pay gap in favour of white consultants.

This has occurred because of national changes to the CEA scheme, which has now been discontinued and only legacy 2018 awards are still paid and must be paid. This means that there are now fewer bonuses being paid, and this impacts more on BME (and female) colleagues because they are more likely to be post-2018 entrants to the Consultant grade.

The impact of the national changes can be seen in the total number of Consultants receiving a bonus in 2025, compared to the total receiving a bonus in 2024 before the rules changed and the CEA scheme was closed to post-2018 colleagues.

In 2024, 348 Consultants received a CEA, whereas in 2025, it is only 92. In 2024, 216 out of the 348 Consultants were of BME ethnic origin. The impact of the national decision is significant for both the gender and the ethnicity bonus pay gap for Consultants. This inequity is enshrined in the national CEA agreement. It will lessen over time with retirements and other natural attrition, but the gap will close more quickly if more equitable arrangements can be agreed nationally.

2025 data	**Number of Consultants White**	**Number of Consultants BME**	**Number of Consultants Not known**
Number of Consultants	106	268	13.54
Bonus received	32	58	2
% of eligible employees (Consultants) receiving bonus (CEA)	30.2%	21.6%	14.8%
Total receiving Bonus	**92 (348 in 2024, of which 216 were BME)**		

5. Next Steps and Action Plan

It has been identified where the Trust needs to take action, which will be taken forward within the context of the overall LCHG strategic objectives, the LCHG EDI Objectives 2025-2026 and the NHS EDI Improvement Plan.

The Ethnicity Pay Gap action plan will be developed as an LCHG Group Action Plan this year and will be discussed further with key stakeholders such as the Race, Ethnicity and Cultural Heritage network (RE&CH) and CODE

Staff Network, starting with the leads. It will also take account of the Gender Pay Gap reports and resulting actions, to be discussed further with the Women's Staff Network, and the Men's Staff Network.

Disability Pay Gap reporting is also a requirement of the NHS EDI Improvement Plan, with Trusts required to implement an improvement plan to analyse the data and identify any improvements required now (2025) and by other protected characteristics by 2026. The data will now be requested as NHS England have confirmed that a standard Business Intelligence report has been built and published in ESR.

Themes identified as areas for action in both Gender and Race Pay data are:

- Inclusive Recruitment – improvement of WRES 2 indicator (likelihood of job offer from shortlisting) through the inclusive recruitment project, working with the Inclusive Recruitment Champion, considering this from both a race and gender perspective.
- Explore declining trend of female leaders at middle and upper pay quartiles, identify root cause(s) and act accordingly.
- Work with the Talent Academy, Women's Network and Men's Network, to encourage more men into areas where they are underrepresented (i.e. at the lower pay quartiles) and continue to encourage women into occupations where they are under-represented, including science, technology, engineering and mathematical (STEM) roles.
- Progression as well as pay – develop a Group wide approach to talent management, which is strategic and inclusive, allowing for equitable rates of career progression.
- Continuing to apply pay rules fairly and consistently, and addressing any anomalies identified through further analysis of specific gaps identified in this report.

Appendices

Appendix 1 – By Ethnic Origin Grouping, Mean and Median Hourly Rates

Ethnic Origin Grouping	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
Asian	£25.75	£19.43	1,874
Black	£24.08	£19.10	498
Mixed	£25.44	£20.06	153
Not Stated	£26.67	£19.57	141
Other	£29.10	£23.19	284
White British	£19.22	£16.53	6,891
White Other	£21.81	£16.90	582
% Diff White British - White Other	-£13.46	-£2.23	92
% Diff White British - Asian	-£33.97	-£17.55	73
% Diff White British - Black	-£25.31	-£15.52	93
% Diff White British - Mixed	-£32.34	-£21.36	98
% Diff White British - Other	-£51.41	-£40.27	96
% Diff White British - Not Stated	-£38.77	-£18.36	98

Appendix 2 Mean Ethnicity Pay Gap by Band for Agenda for Change and Medical and Dental workforce

Agenda for Change

Banding	White Sum of FTE	BME Sum of FTE	Not Stated Sum of FTE	White Mean Salary (£)	BME Mean Salary (£)	Not Stated Mean Salary (£)	Diff White - BME Difference £	Diff White - BME Difference %
Band 1 & Apprentice	19.43	*	*	£22,235.35	£15,813.70	£23,615.00	£6,421.65	28.88%
Band 2	1083.18	104.64	10.07	£23,615.00	£23,615.00	£23,615.00	£0.00	0.00%
Band 3	1443.00	277.69	11.39	£25,064.88	£24,482.58	£24,569.36	£582.29	2.32%
Band 4	521.74	39.46	11.18	£27,742.47	£27,084.77	£27,773.46	£657.69	2.37%
Band 5	970.91	1097.29	22.39	£33,507.84	£31,278.16	£31,508.20	£2,229.68	6.65%
Band 6	900.80	225.31	17.67	£41,290.06	£38,576.80	£38,223.28	£2,713.26	6.57%
Band 7	628.07	40.68	*	£49,414.64	£47,743.04	£51,056.11	£1,671.60	3.38%
Band 8A	286.05	28.80	*	£56,862.25	£56,390.73	£57,900.43	£471.52	0.83%
Band 8B	94.62	8.00	*	£67,625.15	£67,254.00	£68,933.56	£371.15	0.55%
Band 8C	30.22	*	*	£80,982.20	£83,244.54	£78,814.00	-£2,262.34	-2.79%
Band 8D	17.80	*		£96,212.84	£101,677.00	£0.00	-£5,464.16	-5.68%
Band 9	22.82	*		£113,404.69	£121,271.00	£0.00	-£7,866.31	-6.94%
VSM	*	*		£132,481.25	£143,850.00	£0.00	-£11,368.75	-8.58%
Exec Director	8.00			£172,639.50	£0.00	£0.00	£172,639.50	100.00%

Gaps highlighted in yellow, and yellow and turquoise are those requiring further exploration, as per the action plan.

Medical and Dental by Grade

Banding	White Sum of FTE	BME Sum of FTE	Not Stated Sum of FTE	White Mean Salary (£)	BME Mean Salary (£)	Not Stated Mean Salary (£)	Diff White – BME Difference £	Diff White - BME Difference %
General Medical Practitioner	*			£125,033.12	£0.00	£0.00	£125,033.12	100.00%
Consultant	105.90	267.99	13.54	£131,069.46	£124,857.46	£128,961.58	£6,212.01	4.74%
Associate Specialist	*	18.76		£116,361.00	£115,494.92	£0.00	£866.08	0.74%
Staff Grade		*		`	*	*	-£87,867.00	-100.00%
Specialty Doctor	10.34	204.51	14.55	£83,129.29	£83,469.26	£86,208.44	-£339.97	-0.41%
Specialist		*		£0.00	£99,630.22	£0.00	-£99,630.22	-100.00%
GPCA/Hospital Practitioner	*	*		*	*	*	£15,956.39	18.56%
Specialty Registrar	43.97	216.90	*	£57,001.46	£55,832.59	£60,369.97	£1,168.87	2.05%
Foundation Year 2	12.94	135.55	*	£42,008.00	£42,008.00	£42,008.00	£0.00	0.00%
Foundation Year 1	37.00	62.84	*	£36,616.00	£36,616.00	£36,616.00	£0.00	0.00%

* Data suppression applied below 8 due to very low numbers of colleagues at these bands/grades.
Gaps highlighted in yellow are the areas for further investigation and those in green show equality of pay.

NHS
Lincolnshire Community and Hospitals NHS Group

Ethnicity and Gender Pay Gap Reports
Lincolnshire Community Health Services NHS Trust

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3rd March 2026*
Agenda item number	*10.2*
Report title	*Ethnicity and Gender Pay Gap Reports - Lincolnshire Community Health Services NHS Trust*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Approval* • *Assurance* • *Information*
Accountable Director	*Claire Low, Chief People Officer*
Author(s)	*Michael Du Rose, Associate Director of People*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial Assurance*
Prior approval process, if applicable	*EDI Group – November 2025* *People Committee – 13th January 2026*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *Consider the information contained within this report.* • *Approve the report for publication on the Trust's website.*

Assurance Rating Key:

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	

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

Executive Summary

In line with national guidelines, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) reports Gender Pay Gap data based on the snapshot date of 31st March 2025.

Lincolnshire Community Health Services NHS Trust (LCHS) is part of a group arrangement with United Lincolnshire Hospitals NHS Trust (ULHT), together forming the Lincolnshire Community and Hospitals NHS Group (LCHG). While the Board and senior leadership team operate as one, individuals remain employed by their original organisations. This structural arrangement impacts reporting, particularly at senior levels and should be considered when interpreting the data.

For the Gender Pay Gap, women earn £0.917 for every £1.00 earned by men when comparing median hourly pay. This represents an 8.3% gap, which is a slight improvement from last year's 8.8%. The mean hourly pay gap shows women earning 16.7% less than men, again a marginal improvement from 16.8% last year. In terms of bonus pay, women receive £0.60 for every £1.00 men receive, whereas last year the gap was zero. This change reflects national changes to Clinical Excellence Awards (CEAs), which now only apply to consultants on the legacy 2018 scheme. Women hold 79.6% of the highest paid roles, a decrease from 89.2% last year, and 91% of the lowest paid roles, an increase from 79.4% last year. Middle quartiles remain high at between 85% and 88% female representation. These shifts reflect the formation of the LCHG senior leadership team and changes in workforce composition. Nationally, the UK median gender pay gap is 13.1%, compared to LCHS's 8.3%, indicating the Trust performs better than the national average.

For the Ethnicity Pay Gap, White colleagues earn £0.986 for every £1.00 earned by Black and Minority Ethnic (BME) colleagues, equating to a -1.43% gap, meaning White colleagues earn slightly less. The mean hourly pay gap shows White colleagues earning 16.8% less than BME colleagues. All eligible consultants received Clinical Excellence Awards, so there is no ethnicity-based bonus gap. Additional analysis by pay band was undertaken due to the impact of the LCHG structure on senior-level representation.

It is important to note that both pay gaps are not equal pay issues. The Trust adheres to national NHS job evaluation schemes ensuring equal pay for equal work. Variations reflect workforce composition, structural changes, and national policy changes such as CEAs.

In summary, for LCHS the Gender Pay Gap shows a small improvement year-on-year and is better than the national average, while the Ethnicity Pay Gap is negative, largely influenced by workforce structure and senior band representation. The Trust will continue monitoring, undertake targeted workforce development, and maintain transparency in reporting.

These reports have previously been approved by the People Committee on 13th January 2026. The Board is asked to approve the reports, for publication on the Trust's website by the statutory deadline of 31st March 2026.

NHS
Lincolnshire Community Health Services
NHS Trust

Lincolnshire Community Health Services NHS Trust Ethnicity Pay Gap Report 2025-2026

Caring and building a healthier future for all

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Ethnicity Pay Gap Report – Lincolnshire Community Health Services NHS Trust 2025-2026

1. Introduction

Unlike the Gender Pay Gap, there is no statutory requirement to report and act on Ethnicity Pay Gap data. However, for NHS organisations, there is a mandatory requirement through High Impact Action 3 of the NHS EDI Improvement Plan. This report is published in fulfilment of this mandatory duty and to seek to address any gaps identified through an agreed, co-produced action plan.

In line with national guidelines, when reporting Ethnicity Pay Gap data, Lincolnshire Community Health Services (LCHS) is working on the data as at the previous 31st March. This means the snapshot date for data in this report is 31st March 2025. This is also aligned to the Gender Pay Gap snapshot date and reporting period.

There is no requirement for the ethnicity pay gap data to be uploaded to a gov.uk portal, unlike the gender pay gap data, as it is not a statutory requirement. However, the data in this report will be published on the Trust's website no later than end March 2026, following People Committee and Trust Board approval.

2. Executive Summary

It should be noted that Lincolnshire Community Health Services NHS Trust (LCHS) is in a group arrangement with United Lincolnshire Teaching Hospitals NHS Trust (ULTH) – together known as Lincolnshire Community and Hospitals NHS Group (LCHG). The Board and senior leadership team have come together as one single team, however, individuals remain employed by their original organisations. This means that those individuals in senior leadership positions will be reported within separate organisational data and therefore this has impacted on the reporting data which is not wholly representative of the actual workforce, particularly at the more senior bands.

In this Trust overall, White colleagues earn £0.986 for every £1.00 that Black and Minority Ethnic colleagues earn, based on median hourly rate.

The median is the generally accepted main indicator across all organisations who take part in pay gap reporting. The Trust has a median ethnicity pay gap of -1.43%% overall, with White colleagues earning 1.43% less than Black and Minority Ethnic colleagues.

For the less reliable (but still reportable) mean or average, the ethnicity pay gap is -16.8%, with White colleagues earning 16.8% less than Black and Minority Ethnic colleagues.

Further analysis beyond the data provided by the standard ESR ethnicity pay gap report has been undertaken because of these structural influences on the ethnicity pay gap. This report therefore contains an analysis by each band for Agenda for Change and Medical and Dental colleagues to allow for a more rounded picture of the ethnicity pay gap.

In an NHS Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce. Of those eligible for this bonus, all received one. There have been national changes to the CEA scheme which has now been discontinued and only legacy 2018 awards are still paid.

It is important to note that the ethnicity pay gap is not the same as an equal pay gap, e.g. White colleagues being paid more than BME colleagues for doing the same job (or vice-versa) which would be unlawful. The Trust follows the national NHS job evaluation schemes to ensure equal pay for equal work.

3. Methodology and Definitions

Whilst the two constituent trusts of the Lincolnshire Community and Hospitals Group (LCHG) each have a duty to report on their ethnicity pay gaps in their own right, a Group Ethnicity Pay Gap action plan has been developed and further analysis of the data as a Group has been undertaken in preparing this.

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report. This national report unfortunately did not include ethnicity pay gap by band, which is essential to understanding an accurate picture.

For the purposes of these calculations, pay includes basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay and pay for piecework.

Pay does not include overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of a vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

What does median mean?

This is the difference between the hourly pay of the median white colleague and the hourly pay of the median black or minority ethnic colleague. The median for each is the person who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the 'typical' situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all ethnicity pay gap issues will be picked up. They could also fail to pick up as effectively where the ethnicity pay gap issues are most pronounced in the lowest paid or highest paid employees.

What is the meaning of mean?

The mean ethnicity pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of white colleagues, and the mean hourly pay of black and minority ethnic colleagues. A mean involves adding up all the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure, which is why the median is used as the headline figure in ethnicity pay gap reporting.

Unfortunately, the median is not available for pay gap reporting by each band. The reporting by band based on the mean is already an additional step taken beyond the ESR standard BI report.

4. About our Results

At LCHS, the organisation-wide median ethnicity pay gap is -1.43% and the organisation-wide mean is -16.8%. This means that overall, the ethnicity pay

gap exists for white colleagues as a whole group i.e. earning less than Black or Minority Ethnic (BME) colleagues as a whole group.

The cause of this relates to how the workforce is structured (i.e. pay quartile distribution) and occupations which have attracted larger numbers of BME and internationally-educated colleagues with proportionally large number of Asian colleagues at the higher paid bands. This is contrasted with a more even distribution of White colleagues across all four pay quartiles, compared to ULTH.

Mean and Median Ethnicity Pay Gap

LCHS – Median and Mean Pay Gap %

Ethnic Origin Grouping Summary	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
BME	23.6383	18.9254	168
Not Known	22.2917	20.7889	18
White	20.2303	18.6589	2,127
% Diff White - BME	-16.8462	-1.4281	92
% Diff White - Not Known	-10.1900	-11.4153	99
Median Ethnicity Pay Gap LCHS	**-1.43%**	**Mean Ethnicity Pay Gap LCHS**	**-16.8%**

Further breakdown by more-detailed ethnic origin groupings is available at Appendix 1. It is not possible to report here on each ethnic origin separately, because the majority of options within ESR have less than 8 colleagues selecting them, and often only 1 colleague, which would lead to issues of confidentiality.

Pay Quartile Distribution by Ethnicity Grouping

Structurally, LCHS shows a more even distribution of White British, White Other, Asian and Black colleagues compared to ULTH. The medical and dental workforce being much smaller at LCHS, there is greater equity. It is however noted that there is a higher proportion of Asian and Black colleagues in quartile two (second lowest pay quartile) compared to the proportions for White British colleagues.

Quartile	Asian	Black	Mixed	Not Stated	Other	White British	White Other
1	5	6	6	2	3	541	15
2	31	22	6	4	2	486	27
3	23	13	7	9	1	510	15
4	27	8	6	3	2	516	17

Although the ethnicity pay gap overall, organisation-wide, is much smaller at LCHS than it is at ULTH, it is still essential to report on and consider any pay gaps at each band, and within the Agenda for Change and Medical and Dental Workforce as a further step in understanding the overall, organisation-wide ethnicity pay gap accurately.

By Band – Agenda for Change

For colleagues working within the agenda for change Bands 5-7 there are significant pay gaps for BME colleagues, and from Band 8a and 8b this is significantly better.

There is a large pay gap at B1/Apprentice which requires further exploration, however extensive work is carried out by the Talent Academy to attract and secure diverse new entrants to the workforce and this has been measured and recognised nationally as part of the Top 100 Apprentice Employer Awards, with the LCHG Talent Academy ranking in the Top 50.

The significant gaps at Bands 5, 6 and 9 require further exploration to confirm if these are service-related and therefore objectively justifiable as part of applying Agenda for Change increments fairly and consistently, and any other legitimate factors. The gap appears to start at Bands 3 and 4, albeit by a much smaller percentage.

Gaps could legitimately be service-related (gaining of pay increments) or related to a greater concentration of roles which attract legitimate allowances (for example, out-of-hours, on-call, unsocial hours payments etc.) held by White colleagues. Until further analysis takes place, it is not yet possible to confirm this for certain.

In the table below and in the full breakdown at Appendix 2, it is also important to note progression gaps where there are proportionally low numbers or no BME colleagues at that band. This is more pronounced in the LCHS data than in the ULTH's, which is contained in the separate ULTH Ethnicity Pay Gap Report, however it is a factor which requires attention across the whole Group.

The yellow highlighted pay gaps in the table below are those which are noted in the action plan for deeper analysis to establish the reasons for these gaps at these bands, and whether they are objectively justified.

LCHS – Gap by Workforce and Band Agenda for Change

Mean salary by Ethnic Group pay band/grade

Overall AFC Mean Pay Gap: -0.96%	Diff White - BME Difference £	Diff White - BME Difference %
Band 1 and Apprentices	£22,588.32	No BME colleagues at this band
Band 2	-£51.55	-0.22%
Band 3	£84.14	0.33%
Band 4	£472.88	1.72%
Band 5	£2,033.04	6.12%
Band 6	£1,435.52	3.62%
Band 7	£402.26	0.81%
Band 8A	£668.05	1.18%
Band 8B	£66,625.66	No BME colleagues at this band
Band 8C	-£7,226.47	-0.92%
Band 8D	£89,969.33	No BME colleagues at this band
Band 9	£3,177.20	2.93%

By Band – Medical and Dental

At LCHS, with its small medical and dental workforce compared to ULTH, there is a mean ethnicity pay gap of 17.63%, with BME colleagues earning less. This is a small group of 22.78 Full-Time Equivalent colleagues in the Medical and Dental workforce at LCHS, and the mean is therefore more subject to distortion.

The largest pay gap within the medical and dental grades at LCHS is at Associate Specialist (BME colleagues earning 5.12% less). The reasons for the pay gap need further analysis to confirm that the difference is service-related or some other legitimate reason. Likewise, there is a pay gap for White colleagues at Consultant grade, earning 2.78% less, which also needs further exploration. These areas highlighted in yellow in the table below require further exploration.

LCHS – Pay Gap by Workforce and Band for Medical and Dental

Overall Medical and Dental Mean Pay Gap: 17.63%	Diff White - BME Difference £	Diff White - BME Difference %
Consultant	-£3,551.09	-2.78%
Deputy Director	*	No BME staff at this grade
General Medical Practitioner	-£233.13	-0.16%
Specialty Registrar CT 2	*	No White staff at this grade
Associate Specialist	£5,602.80	5.12%

Bonus pay gap (Clinical Excellence Awards)

In an NHS Trust, bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce. LCHS employs a very small number of Consultants. Two White Consultants and two BME Consultants received a bonus (CEA) in 2025.

National changes to the CEA scheme, which has now been discontinued, mean that only legacy 2018 awards are still paid and must be paid. Generally speaking this can affect female and BME Consultants disproportionately as they are likely to be more recent entrants to the grade.

Unfortunately, the 2024 data was not available to see the impact - however the number of Consultants employed by LCHS and the number receiving a bonus in 2024 has not significantly changed.

5. Next Steps and Action Plan

It has been identified where the Trust needs to take action, which will be taken forward within the context of the overall Lincolnshire Community and Hospitals NHS Group (LCHG) strategic objectives, the LCHG EDI Objectives 2025-2026 and the NHS EDI Improvement Plan.

The Ethnicity Pay Gap action plan will be developed as an LCHG Group Action Plan this year and will be discussed further with key stakeholders such as the RE&CH/CODE Staff Network, starting with the leads. It will also take

account of the Gender Pay Gap reports and resulting actions, to be discussed further with the Women's Staff Network, and the Men's Staff Network.

Disability Pay Gap reporting is also a requirement of the NHS EDI Improvement Plan, with Trusts required to implement an improvement plan to analyse the data and identify any improvements required now (2025) and by other protected characteristics by 2026. The data will now be requested as NHS England have confirmed that a standard Business Intelligence report has been built and published in ESR.

Themes identified as areas for action in both Gender and Race Pay data are:

- Inclusive Recruitment – improvement of WRES 2 indicator (likelihood of job offer from shortlisting) through the inclusive recruitment project, working with the Inclusive Recruitment Champion, considering this from both a race and gender perspective.
- Explore declining trend of female leaders at middle and upper pay quartiles, identify root cause(s) and act accordingly.
- Work with the Talent Academy, Women's Network and Men's Network, to encourage more men into areas where they are underrepresented (i.e. at the lower pay quartiles) and continue to encourage women into occupations where they are under-represented, including science, technology, engineering and mathematics (STEM) roles.
- Progression as well as pay – develop a Group wide approach to talent management, which is strategic and inclusive, allowing for equitable rates of career progression.
- Continuing to apply pay rules fairly and consistently, and addressing any anomalies identified through further analysis of specific gaps identified in this report.

Appendices

Appendix 1 – By Ethnic Origin Grouping, Mean and Median Hourly Rates

Ethnic Origin Grouping	Mean Hourly Rate	Median Hourly Rate	Total Full Pay Relevant Employees
Asian	26.4339	19.7736	86
Black	20.5871	18.2030	49
Mixed	21.6235	19.0922	25
Not Stated	22.2917	20.7889	18
Other	18.5709	16.0454	8
White British	20.1851	18.7367	2,053
White Other	21.4844	18.2588	74
% Diff White British - White Other	-6.4373	2.5509	96
% Diff White British - Asian	-30.9577	-5.5337	96
% Diff White British - Black	-1.9916	2.8488	98
% Diff White British - Mixed	-7.1263	-1.8972	99
% Diff White British - Other	7.9967	14.3641	100
% Diff White British - Not Stated	-10.4367	-10.9527	99
% Diff White British - NULL	100.0000	100.0000	100

Appendix 2 Mean Ethnicity Pay Gap by Band for Agenda for Change and Medical and Dental workforce

Agenda for Change

	White	BME	Not Stated	White	BME	Not Stated	Diff White - BME	Diff White - BME
	Sum of FTE	Sum of FTE	Sum of FTE	Mean Salary (£)	Mean Salary (£)	Mean Salary (£)	Difference £	Difference %
Band 1 and Apprentices	*			*			£22,588.32	100%
Band 2	120.24	*		£23,563.45	*		-£51.55	-0.22%
Band 3	423.50	19.69	*	£25,264.32	£25,180.19	*	£84.14	0.33%
Band 4	146.70	*	*	£27,519.68	*	*	£472.88	1.72%
Band 5	321.03	71.80	*	£33,209.35	£31,176.31	*	£2,033.04	6.12%
Band 6	348.84	20.24	*	£41,457.61	£40,022.08	*	£1,435.52	3.62%
Band 7	314.29	16.40	*	£49,694.75	£49,292.49	*	£402.26	0.81%
Band 8A	91.80	*	*	£56,582.25	*	*	£668.05	1.18%
Band 8B	29.95			£66,625.66			£66,625.66	100%
Band 8C	*	*		*	*		-£7,226.47	-0.92%
Band 8D	*			*			£89,969.33	100%
Band 9	*	*		*	*		£3,177.20	2.93%

Medical and Dental

	White	BME	Not Stated	White	BME	Not Stated	Diff White - BME	Diff White - BME
	Sum of FTE	Sum of FTE	Sum of FTE	Mean Salary (£)	Mean Salary (£)	Mean Salary (£)	Difference £	Difference %
Consultant	*	*		*	*		-£3,551.09	-2.78%
Deputy Director	*			*			*	100% - no BME colleagues
General Medical Practitioner	*	*	*	*	*	*	-£233.13	-0.16%
Specialty Registrar CT 2		*			*		*	-100% - no White colleagues
Associate Specialist	*	*		*	*		£5,602.80	5.12%

* Data suppression applied below 8 due to very low numbers of colleagues at these bands/grade.

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NHS Trust

Lincolnshire Community Health Services NHS Trust Gender Pay Gap Report 2025-2026

Caring and building a healthier future for all

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Executive Summary

When reporting Gender Pay Gap data, the Trust is working from the data as at 31st March 2025.

It should be noted that Lincolnshire Community Health Services NHS Trust (LCHS) is in a group arrangement with United Lincolnshire Teaching Hospitals NHS Trust (ULTH) – together known as Lincolnshire Community and Hospitals NHS Group (LCHG). The Board and senior leadership team have come together as one single team, however, individuals remain employed by their original organisations. This means that those individuals in senior leadership positions will be reported within separate organisational data and therefore this has impacted on the reporting data which is not wholly representative of the actual workforce, particularly at the more senior bands.

In this Trust, women earn £0.917 for every £1.00 that men earn when comparing median hourly pay. Last year's figure was £0.91 for every £1.00, showing a very small improvement overall. In percentage terms, the median hourly pay gap between men and women is now 8.3%, a small improvement on last year's 8.8% median pay gap.

Women's mean (average) hourly pay was 16.7% lower than men's. Again, as with median hourly pay, there is a very small 0.1% improvement from last year's gap which was 16.8%.

For women who receive a bonus, they receive £0.60 for every £1.00 men receive. In Lincolnshire Community Health Services (LCHS) bonuses are defined as the Clinical Excellence Awards (CEAs) which are only applicable to consultants in the medical workforce. Last year it was equal, 0% bonus pay gap, £1.00 for £1.00. Changes nationally mean that only consultants on the previous (2018) scheme now still receive a bonus.

It is important to note that the Government's Gender Pay Gap portal incorrectly calculates the Trust's bonus pay gap, as it assumes that all of the workforce is on the same terms and conditions and therefore the whole workforce is eligible for a bonus. This is not the case for NHS employees. Our narrative here acknowledges this, and our data reported in this report represents the true picture of the percentage of those eligible for a bonus i.e.

Consultants on Medical and Dental terms and conditions versus percentage of those from that part of the workforce receiving a bonus.

At LCHS, women hold 79.6% of the highest paid jobs (the figure was 89.2% last year), and 91% of the lowest paid jobs (the figure was 79.4% last year).

There has been a decrease of 9.8% in the number of women holding the highest paid jobs, and an 11.6% increase in the number of women holding the lowest paid jobs – this was the case as at the 31st March 2025 snapshot date.

These fluctuations may reflect the changes at the highest-paid level of the organisation, with a newly formed LCHG Group Executive and Senior Leadership team during the last year, with some members of this team being employed by the partner organisation (ULTH).

Women still hold between 85-88% of the lower middle and upper middle-paid jobs, a small decrease on last year when it was 87-89%.

The median is the generally accepted main indicator across all organisations who take part in Gender Pay Gap reporting, as it is less vulnerable to distortion by very high or low outliers.

The national Gender Pay Gap in the UK, on current available data (2024)* is 13.1% (median) compared to the Trust's 16.8% gap in 2024. When the latest national Gender Pay Gap data is published, like-for-like comparison will be possible for 2025 data.

It is important to note that the gender pay gap is not the same as an equal pay gap, i.e. men being paid more than women for doing the same job (or vice-versa) which would be unlawful. The Trust follows the national NHS job evaluation schemes to ensure equal pay for equal work.

Background

Whilst the two constituent trusts of the Lincolnshire Community and Hospitals Group (LCHG) each have a statutory duty to report on their gender pay gaps in their own right, a Group Gender Pay Gap action plan has been developed, and further analysis of the data as a Group has been undertaken in preparing this.

Employers with 250 or more employees have been required to publish information on the pay gap between male and female employees since 31

March 2017, under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which can be found at The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (legislation.gov.uk).

Organisations in the public sector, such as NHS Trusts, are required to report on the gov.uk Gender Pay Gap website (Search and compare gender pay gap data - Gender pay gap service - GOV.UK), against a set of six key indicators, based on data from 31st March each previous year, for example, the "snapshot date" for this report is 31st March 2025. Organisations are then required to publish the data and a narrative ("Gender Pay Gap Report") so that employees and members of the public can access the data and report, along with an action plan to address disparities, by 31st March each year, for example, this report is to be published on the Trust's website by 31 March 2026 (Gender pay gap reporting – Lincolnshire Community Health Services).

Private sector employers with 250 or more employees are also required to publish Gender Pay Gap information, albeit with a slightly later publication date of 5th April each year.

In preparing this report, the author has consulted and followed the NHS Employers Gender Pay Gap guide: Addressing-your-gender-pay-gap-guide.pdf (nhsemployers.org) which was co-produced with the Health and Care Women Leaders Network.

Understanding the Gender Pay Gap Calculations

The six key indicators that the Trust is required to report on are:

1. percentage of men and women in each hourly pay quarter (lower, lower middle, upper middle and upper quartile) by number of employees.
2. mean (average) gender pay gap using hourly pay.
3. median gender pay gap using hourly pay.
4. percentage of men and women receiving bonus pay.
5. mean (average) gender pay gap using bonus pay.
6. median gender pay gap using bonus pay.

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework.

Pay does not include, overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of a vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the CEAs to consultants, following the NHS Employers Gender Pay Gap Guide.

What does median mean?

This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid.

Medians are useful to indicate what the ‘typical’ situation is. They are not distorted by very high or low hourly pay (or bonuses). However, this means that not all gender pay gap issues will be picked up. They could also fail to pick up as effectively where the gender pay gap issues are most pronounced in the lowest paid or highest paid employees.

What is the meaning of mean?

The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all the numbers and dividing the result by how many numbers were in the list. Very high or very low pay can distort this figure, which is why the median is used as the headline figure in gender pay gap reporting.

About our results

The Trust’s Gender Pay Gap has been on a generally decreasing (i.e. improving) trend since reporting began, in line with the national trend both inside and outside of the NHS.

The data sets on which the Trust's Gender Pay Gap report for the current reporting cycle are based can be viewed in appendix 1.

Since reporting was made a statutory requirement in 2017, the median pay gap is gradually getting smaller, by 3.2% in nine years for this, the most reliable measure. Most of this progress has been seen in the last two years and has now been sustained for two consecutive years, whereas previously the figures would regularly fluctuate. The improvement since reporting began for the less-reliable average (mean) is 4.4%, and again this has been sustained for two years now.

The trend data from 2017 for the median hourly rate and the average hourly rate (mean) are noted as follows:

Reporting Year	Median Hourly Rate Gap %	Average Hourly Rate Gap %
2017	11.5	21.1
2018	18.9	21.5
2019	17.9	25.5
2020	13.1	22.8
2021	16.4	26.3
2022	18.5	24.3
2023	16.2	20.6
2024	8.8	16.8
2025	8.3	16.7

Trend charts for the Median Hourly Rate and the Average Hourly Rate (mean) are included in appendix 2.

Gender Disparity – Mean Salary

As with previous years, the main driver of the Trust's gender pay gap remains the structure of the NHS workforce, with female colleagues comprising the majority of the lower paid roles and majority of the male colleagues in the Trust occupying higher paid roles.

For this reason, further analysis on the gender pay gap by band has been undertaken. Please note that this information is only available as the mean rather than them. Overall, the mean Gender Pay Gap for all colleagues on Agenda for Change terms and conditions of employment is small, at £58.09 per year less for women and a percentage gap of 0.1% overall, for Bands 1/Apprentice to Band 9 inclusive. This does not include those on Very Senior

Management (VSM) contracts and Executive Directors, of which there are fewer on the LCHS payroll than in previous years' reporting due to the new Group Executive Leadership team structure, however any outlying high salaries can still have a significant distorting effect.

To assist further, each band has been analysed. This does reveal a couple of "hotspots" which would benefit from further analysis as indicated in the table below.

Agenda for Change

Band	Difference in mean salary	Pay Gap % (Mean)
Band 5	+£2,229.38	6.5% less for men
Band 8b	+£842.85	1.3% less for men
Band 8c	+£1,885.17	2.4% less for men
Band 8d	+£2,702.00	3.0% less for men
Band 9	-£7,943.00	7.0 less for women

Where gaps of more than 1% exist, as detailed in the table above, they warrant further analysis to confirm that the difference is service-related and therefore objectively justifiable. This should be reviewed through the EDI governance route and agreed action taken if there are any unjustifiable gaps.

Medical and Dental

The Trust has a comparatively small medical workforce, employing 6.4 Full-Time Equivalent (FTE) female doctors, and 14.4 FTE male doctors. The overall gender pay gap for the medical and dental workforce is +25.6% (mean). This means that overall, the female medical workforce is paid more than men. However, as with all averages, in a small workforce a significantly higher or lower salary can distort the outcome substantially, which is the case for the large gender pay gap for men at Consultant grade:

Band	Difference in mean salary	Pay Gap % (Mean)
GP	-£6,257.21	4.4% lower for women
Consultant	+£61,679.87	45% lower for men
Associate Specialist	-£2,317.58	2.2% lower for women

As with the Agenda for Change workforce, a couple of hotspots have been identified as warranting further investigation, namely to establish the objective justification behind the substantial gap at Consultant and GP grades, and this is therefore reflected in the action plan. Also, the bonus pay gap between male and female consultants now shows female consultants at a disadvantage by approximately 40%, which may be connected to the mean salary pay gap, which is reversed and shows male consultants earning 45% less in their salaries.

Gender Disparity – Pay Quartiles

At this Trust women hold 79.6% of the highest paid jobs (the figure was 89.2% last year), and 91% of the lowest paid jobs (the figure was 79.4% last year).

Women hold between 85-88% of the lower middle and upper middle-paid jobs, whereas last year it was 87-89%. This represents a slight decrease for which the reason is not currently known. One of the factors may be the change in the workforce structure at LCHS, due to the increasing integration of teams across the Group. However, this is a working assumption and further analysis is warranted.

91.1% of the workforce in the lowest pay quartile are female. This means that women hold 91.1% of the lowest paid jobs. In comparison, 79.6% of the workforce in the top pay quartile are women, so women disproportionately hold lower-paid jobs and this structural imbalance continues to contribute to the overall gender pay gap. Also, there has been a decrease of 9.8% in the number of women holding the highest paid jobs, and an 11.6% increase in the number of women holding the lowest paid jobs - this was the case as at the 31st March 2025 snapshot date. For the highest-paid quartile, the change may be related to the changes at the highest-paid level of the organisation, with a newly-formed LCHG Group Executive and senior leadership team.

Gender Disparity by Pay Quartiles

The proportion of male and female staff in each pay quartile

Quartile	Female	Male	Female %	Male %
1	526	52	91.00	9.00
2	494	84	85.47	14.53

3	509	69	88.06	11.94
4	461	118	79.62	20.38

Gender Disparity – Bonus Pay

Bonus pay relates to the CEAs which only apply to members of the consultant workforce. The relevant workforce equates to just 4.0 FTE, and all members of the relevant workforce received a bonus, 100% of men and women.

Mean and median bonus payments for males and females

Gender	Avg. Pay	Median Pay
Male	£7,900.00	£7,900.00
Female	£5,793.33	£4,740.00
Difference	£2,106.67	£3,160.00
Pay Gap %	26.67	40.00

For every £1 that a male consultant receives, a female consultant receives £0.60. Last reporting year, there was no gender disparity with bonus pay within the Trust. However, due to the cessation of the CEA scheme nationally, new CEA bonuses are no longer paid and therefore only legacy (2018) CEAs are paid. This inequity is enshrined in the national CEA agreements and is not within the Trust's gift to change. That said, the data table on pages 9 and 10 shows that male consultants are paid 45% less in their mean salary than female consultants, therefore the total pay gap between male and female consultants, adding salary plus bonus, is much smaller.

How we will make progress to close the gap

It has been identified where the Trust needs to take action which will be taken forward within the context of the overall LCHG strategic objectives, the LCHG EDI Objectives 2025-2026 and the NHS EDI Improvement Plan.

The Gender Pay Gap action plan will be developed as an LCHG Group Action Plan this year and will be discussed further with key stakeholders such as the Women's Staff Network and Men's Staff Network. It will also take account of the Ethnicity Pay Gap reports and resulting actions, to be discussed further with the Race, Ethnicity and Cultural Heritage network (RE&CH) and CODE Staff Network.

Disability Pay Gap reporting is also a requirement of the NHS EDI Improvement Plan, with Trusts required to implement an improvement plan to analyse the data and identify any improvements required now (2025) and by other protected characteristics by 2026.

Themes identified as areas for action in both Gender and Race Pay data are:

- Inclusive Recruitment – improvement of WRES 2 indicator (likelihood of job offer from shortlisting) through the inclusive recruitment project, working with the Inclusive Recruitment Champion, considering this from both a race and gender perspective.
- Explore declining trend of female leaders at middle and upper pay quartiles, identify root cause(s) and act accordingly.
- Work with the Talent Academy, Women's Network and Men's Network, to encourage more men into areas where they are underrepresented (i.e. at the lower pay quartiles) and continue to encourage women into occupations where they are under-represented, including science, technology, engineering and mathematics, (STEM) roles.
- Progression as well as pay – develop a Group wide approach to talent management, which is strategic and inclusive, allowing for equitable rates of career progression.
- Continuing to apply pay rules fairly and consistently, and addressing any anomalies identified through further analysis of specific gaps identified in this report.

Gender Pay Gap Data on which this report is based

Appendix 1: – Data Tables 2025

Table 1. The mean and median hourly rates for males and females.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	£23.93	£20.35
Female	£19.94	£18.66
Difference	£3.99	£1.69
Pay Gap %	16.67%	8.30%

Table 2. The proportion of male and female staff in each pay quartile.

Quartile	Female	Male	Female %	Male %
1	526	52	91.00	9.00
2	494	84	85.47	14.53
3	509	69	88.06	11.94
4	461	118	79.62	20.38

Table 3. Mean salary for men and women within each Agenda for Change pay band or grade.

	Gender (FTE)		Mean Salary (£)	
Pay Band/Grade	Female	Male	Female	Male
Band 1 & Apprentices	1.43	1.00	£22,992.15	£22,369.29
Band 2	116.01	9.48	£23,404.36	£23,615.00
Band 3	392.30	51.89	£25,311.25	£25,065.97
Band 4	140.50	12.00	£27,516.00	£27,606.67
Band 5	340.13	57.11	£34,165.11	£31,935.73
Band 6	325.05	49.23	£41,533.57	£42,022.68
Band 7	278.74	53.55	£49,783.88	£49,708.20
Band 8A	70.10	28.70	£56,562.40	£57,129.30
Band 8B	19.95	10.00	£66,887.45	£66,044.60
Band 8C	5.20	3.00	£79,945.50	£78,060.33
Band 8D	2.00	1.00	£90,870.00	£88,168.00
Band 9	4.00	2.00	£105,385.00	£113,328.00

Very Senior Manager	2.00	0	£139,975.00	N/A

Table 4. Mean salary for men and women within each Medical Workforce pay band or grade.

	Gender (FTE)		Mean Salary (£)	
Pay Band/Grade	**Female**	**Male**	**Female**	**Male**
General Medical Practitioner	1.97	10.14	£136,229.09	£142,486.30
Consultant	2.78	1.21	£136,416.00	£74,736.13
Associate Specialist	1.65	2.02	£103,614.67	£105,932.25
Foundation Year 2	0	1.00	N/A	£49,909.00

Table 5. Mean and median bonus payments for males and females (Clinical Excellence Awards within the medical workforce consultant pay grade).

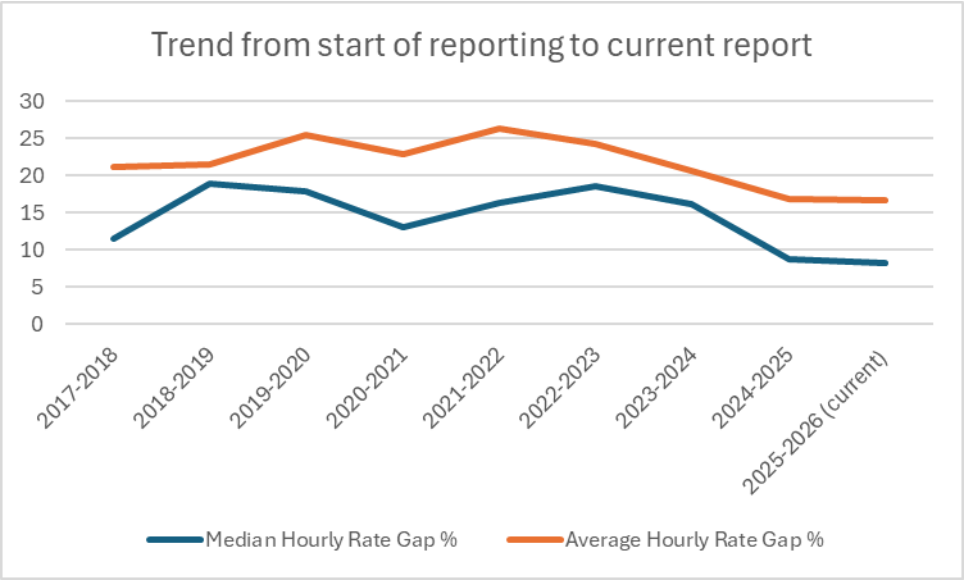
Gender	Avg. Pay	Median Pay
Male	£7,900.00	£7,900.00
Female	£5,793.33	£4,740.00
Difference	£2,106.67	£3,160.00
Pay Gap %	26.67	40.00

Table 6. Number of female and male medical staff receiving a bonus payment.

Gender	Employees Paid Bonus	Total Relevant Employees*	%
Female	2.78	2.78	100
Male	1.21	1.21	100

*NB: adjusted for relevant employee population (consultants on medical and dental terms and conditions), not total workforce headcount.

Appendix 2: – Trend Graph to 2025



NHS
Lincolnshire Community and Hospitals NHS Group

Pay Gap Action Plan

2026-2027

Caring and building a healthier future for all

LCHG Pay Gap Action Plan

NHS EDI Improvement Plan – High Impact Action 3

Gender & Ethnicity Pay Gaps*

*Disability pay gap report pending

	Objective	Actions	Senior Responsible Person	Resources/team members needed	Deadline
1	To explain the ethnicity pay gap in a way which will support and protect all our staff, build trust and understanding, and mitigate the potential for negative and inaccurate press coverage.	Work with the Communications team to develop an "in case" internal and external statement which clearly sets out the ethnicity pay gap and the context in which it exists. Engage with the RE&CH network in January 2026 and discuss the proposed statement with them, as part of their pay gap engagement session. Brief all staff network leads, via	Associate Director (Culture & Wellbeing)	EDI Leads Senior Communications Officer RE&CH leads and network members Other staff network leads.	30th January 2026

		the Council of Staff Networks' arrangements.			
2	To investigate unexplained pay gaps at specific bands and establish if objectively justified.	A) Investigate the pay gaps at the bands highlighted as 'hotspots' in the pay gap reports – answering the question: Why is there an ethnicity or gender gap at this band? For example, is it because of longer service at that band, therefore higher increments have been gained? Are there any other factors such as allowances paid in particular roles? For Band 9 and VSM roles, this review requires a "one payroll" approach as the Group model has had a significant impact.	Deputy Directors of People	Payroll support – data Data analysis support	Data analysis complete by 31st March 2026 Timing of Band 9 and VSM review to take into account "one payroll" approach.
	To take action to mitigate any risks identified – for example to close any unjustifiable gaps.	B) Create action plan to address any pay gaps which are not objectively justified	Deputy Directors of People	EDI advice Employment law advice (if required)	Action plan created by 30th June 2026

				Finance advice	
3	To improve LCHG's performance in WRES (race) and WDES (disability) Indicators 1 and 2 by completing the existing WRES and WDES actions identified for these indicators. Indicator 1 - Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce. Indicator 2 - Likelihood of job offer from shortlisting	A) Implement the WRES and WDES Action Plans published at: NHS Workforce Race Equality Standard (WRES) - United Lincolnshire Hospitals https://www.ulh.nhs.uk/wp-content/uploads/2025/10/LCHG-High-level-WDES-action-plan-V1-3.7.25.xlsx B) Extend reporting on Indicator 2 to include gender (data already available in Trac Equalities standard report) to provide further information to support the career development of women and men	Deputy Directors of People	Implementation leads as identified in the WRES and WDES action plans. EDI team – using Trac reports for WRES & WDES reporting	Timescales during 2026, as identified in WRES and WDES action plans May 2026
4	Explore declining trend of female leaders at middle and upper pay quartiles, particularly at LCHS but	A) Identify where the Group structure may have led to this, and if there are any other factors identified.	Associate Director (Workforce)	AD-Workforce team	May 2026

	also lower middle quartile at ULTH. Identify root cause(s) and act accordingly. Acting early to prevent future impact on pay gap at upper quartiles.	B) Implement the "Mend the Gap" recommendations for all sections of the workforce, not just medical & dental, so that progression barriers such as flexible working and part-time working are removed. See also Talent Management actions below	Associate Directors, (Culture & Wellbeing, Education & Talent and Human Resources)	"Heads of/Leads" for each AD and their teams	September 2026
	To encourage more men into areas where they are underrepresented (i.e. at the lower pay quartiles) and continue to encourage women into occupations where they are under-represented, including STEM roles.	Work with the Talent Academy, Women's Network and Men's Network to develop actions	Associate Director (Education & Talent)	Apprenticeship Engagement Lead, to action	Action Plan developed by May 2026
5	To understand and acknowledge rates of progression as well as pay – then develop a Group wide strategy and plan for Talent Management, which is both strategic and inclusive, allowing for equitable rates of career progression.	A) Establish baseline data on how quickly or slowly colleagues progress, by race/ethnicity, gender and disability B) Gather learning from the impact of the Women's	Associate Directors (Education & Talent, Culture & Wellbeing and Workforce)	"Heads of/Leads" for each AD and their teams	Baseline understanding of data – April 2026 Talent Management

		Network Leadership Programme and the Triple A Programme for Global-Majority colleagues. C) Factor both of the above sources of data into Leadership Development and Talent Management Strategies & Programmes – a Group approach to Talent Management			strategy – July 2026
6	To address gaps in representation at specified bands at LCHS and ULTH, including at the most senior decision-making levels	A) Use the staff networks as a platform to amplify lived experience, create safe spaces for feedback and co-develop talent management solutions. B) Then strengthen early Talent Management & Leadership Development strategies and plans to include targeted development support such as mentoring, return to work & upskilling for those in underrepresented roles C) Identify the “gaps” in	Associate Directors (Education & Talent and Culture & Wellbeing)	EDI, OD and Talent Academy team members	May 2026

		representation across all protected characteristics and wider social determinants of health at senior decision-making levels of LCHG, including Board and GLT. D) Then consider solutions to address the identified gaps, such as a “shadow board” and other options identified by benchmarking with other similar Trusts and wider research into options.			
7	To establish the trend of the ethnicity pay gap to inform discussions about the reasons for the gaps and what has led to them over time	To run the ethnicity pay gap reports for each year back to 2017, establishing how the mean and median has changed over time and present this as a chart. Include this each year of reporting, to mirror Gender Pay Gap reporting of trend.	EDI Leads	Workforce Intelligence/HR Governance colleagues	September 2026

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	*3 March 2026*
Agenda item number	*11.1*

Integration Committee Upward Report of the meeting held on 29 January 2026

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Jim Connolly (Acting Chair), 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 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:	03 March 2026
Report from:	Integration Committee
Report from meeting held on:	29 January 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 29 January 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) Care Group Integration & Group/LIVES Integration
d) District Nursing Transformation
e) Newton Commercial Business Case and Delivery Plan

The improvements in space utilisations have continued since a new centralised booking process for Open Space utilisation commenced in November 2025 in ULTH. The Estates team was planning to implement the same centralised space booking process in LCHS as well.

The Committee was updated on the work being undertaken to submit the Group's 3-year operational plans to NHSE by 12 February 2026. The Group will be working to agree a credible financial position which sets out the Group's approach to achieving a challenging CIP target. The Committee was informed that the Group will continue to refine and develop the detailed operational delivery plans beyond 12 February 2026.

The Committee received an update on the progress made after the integration of LIVES Falls Response Cars with the Group's Clinical Assessment Service (CAS) in October 2025. The remit of the integrated LIVES Community Response Service is to enable faster identification and dispatch to patients who have fallen, reducing long-lie times, improving

outcomes, and lowering reliance on the East Midlands Ambulance Service (EMAS). The Committee was also updated on steps being to further improve response times by the introduction of new LIVES transport vans, as well as new operational practices which would, in the future, support the automatic dispatch to vehicles to patients who have fallen. The automatic dispatches initiative will have no human involvement.

The Committee received a report on the District Nursing Transformation programme. The implementation of the programme will enable district nursing to operate as a specialist, sustainable, population-focused service capable of delivering consistent and high-quality care for Lincolnshire. The transformation programme will realign district nursing from a fragmented team to a population-based model aligned to Integrated Neighbourhood Team (INT) footprints. Under the auspices of the new model, resources will be redistributed so that staffing levels, leadership oversight and skill mix will more consistently and equitably reflect neighbourhood need.

The Committee recommended that the Group Board approve the Newton Commercial Business Case at the Group Board's extraordinary meeting on 11 February 2026.

Assurances in respect of Objective 3b:

a) Alliance Steering Group Upward Report

The Committee noted the Alliance Steering Group's upward report, which highlighted the establishment of a Left Shift Programme Board in January 2026 to support the Group's 'Left Shift' agenda. The Programme Board will oversee the transition of 7 services from the acute setting to the community setting. This will help improve patient care and reduce reliance on the Group's acute setting.

Assurances in respect of Objective 3c:

a) Research & Innovation Governance Group Upward Report
b) Update on System Digital Leadership Team
c) Shared Care Record Novation

The Committee supported a proposal for the restructuring of the Research & Innovation Governance Group (RIGG) into a weekly Operations Group meeting, and a monthly Strategic Oversight Group. Both groups will report into the Integration Committee.

The Committee was also informed of the steps being taken to develop a multidisciplinary Research & Innovation Strategy. The development process will include stakeholders such as midwives, nurses, doctors and allied health professionals to ensure that research is embedded in business-as-usual activities.

The Committee was updated on the transfer of the hosting of the Lincolnshire System Digital Team from the ICB to the Group. The system had historically been resourced by the Group but had been hosted by the ICB. On becoming an ICB cluster, it was decided that the Digital Team be hosted by the Group so that it maintains its integrity as Lincolnshire focused team. The Digital Team will be placed within the Group's Alliance Care Group structure but would operate as independent partners of the Group and other NHS providers in the Lincolnshire system.

The Committee received a report which informed members that the novation of the contract for the Lincolnshire Shared Care Record from the ICB to the Group will be completed by 30 January 2026. The Committee also supported extension of the contract to April 2028.

Assurances in respect of Objective 3d:

a) Productivity, Improvement and Transformation Oversight Forum (PITOF) Group Upward Report
b) Sustainability & Green Plan Update

The Committee received a PITOF report which indicated that the current main area of concern was the medical staffing workstream, which was rated as red. The related 2025/26 CIP target was no longer deemed achievable, and actions were being implemented to ensure that the 2026/27 CIP target can be achieved.

The Committee received information on the submission of additional funding requests for solar photovoltaic (PV) systems at the Pilgrim, Lincoln and Grantham hospitals.

Assurances in respect of other areas:

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

The Committee received a Staff Story presentation on the Group's Tuberculosis (TB) Service which highlighted the significant improvements achieved in patient access, patient and clinical outcomes and experience over the last 18 months.

The presentation on the TB Service noted that these improvements were achieved through a service redesign supported by digital innovation, and without extra financial investment. The Committee was informed that the TB Service team had been invited to showcase the improvement initiatives that had been implemented at a GIRFT conference in February 2026.

The Committee received the performance dashboard noting the performance data being reported, and the steps being undertaken to continue improving on the data provided by the dashboard.

The risk register was received with the Committee noting the movement in risks presented.

The policy position was received and noted in respect of research policy documents.

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

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

a) None

4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

Jim Connolly (Acting Chair), Non-Executive Director

29 January 2026

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	*3 March 2026*
Agenda item number	*11.1*

Integration Committee Upward Report of the meeting held on 20 February 2026

Accountable Director	*Daren Fradgley, Group Chief Integration Officer*
Presented by	*Rebecca Brown, Non-Executive Director /Deputy Chair*
Author(s)	*Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs*
Recommendations / decision required	*The Group Board is asked to:* • *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:	03 March 2026
Report from:	Integration Committee
Report from meeting held on:	20 February 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 20 February 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) – 2026/27 Plan
c) Update on Lymphoedema Service
d) Palliative & End of Life Update

The Estates and Facilities Upward Report informed the Committee that improvements in space utilisations have continued since a new centralised booking process for Open Space utilisation commenced in November 2025 in ULTH.

Plans for the centralised booking process to be rolled out to LCHS colleagues have begun and steps were being implemented to ensure that the launch of the process is successful. The Committee was informed new process will streamline the booking process to a centralised team to ensure that space under-utilisation was reduced and provide the Group with financial savings.

Progress Living remains a financial concern due to occupancy rates continuing to decline to 55.5% in December 2025, from 71% in April 2025. The Progress Living contract stipulates that the Group was liable for the difference if a guaranteed occupancy rate of 85.3% was not achieved.

Steps being implemented to increase the occupancy rates include the offering of discounted rates to contractors, widening the audience to which

advertise the accommodations are advertised to, and the upgrading of some of the accommodations. The Group also plans to negotiate revised contacts when they fall due in 2026 and 2028.

The Committee received a report on the progress to roll out an Electronic Meal Ordering System (EMO). The report noted that the timeline for the roll out has been amended due to the requirements of digital clinical safety to resolve several data hazards, requests and challenges not originally envisaged. The Group continue to plan for the launch of EMO and train all catering and nursing staff on how to utilise it.

The Estates and Facilities Upward Report updated the Committee on the developments around various capital projects, including:

a. the Lincoln Maternity Scheme which had progressed through various design stages and was at Royal Institute of British Architects (RIBA) Stage 3. The Stage 3 design plan was scheduled to be submitted no later than 30 March 2026. The report noted that current funding agreement will expire in March 2026, and new funding is required to progress the design to RIBA Stage 4. Though completing Stage 4 was essential for project delivery, the Committee was assured that the current lack of secure future funding was a minor risk.

b. The Stroke/Navenby demolition and structural alteration works has been delayed due to unforeseen infrastructural challenges on the site. These unforeseen challenges have required further architectural updates and coordination, which has delayed the release of Building Works in Connection (BWIC) drawings and subsequently pushed back the start of partition works.

c. The Endoscopy Service building project was progressing at pace and was scheduled to be completed by the end of May 2026. A robust transition plan has been developed with stakeholders to ensure the Endoscopy Service becomes fully operational with the minimum practicable disruption to clinical care.

d. The Pilgrim Hospital ED building work continues and was on track to be completed early in May 2026. The construction company was working on weekends to ensure the complete target was achieved.

e. Community Diagnostic Centres (CDC) – After the approval of the Boston CDC business case in November 2025, several steps including the identification and purchase of the building site has been progressed. The building project was scheduled to be completed in March 2026. The Lincoln CDC extension project was progressing and remained on track to be completed by April 2026.

The Committee was provided with **substantial assurance** by the Estates and Facilities Upward Report.

The Committee received a report which provided an overview of the 2026/27 Annual Plan which was submitted to NHSE on 12 February 2026. The report

described the approach for closing the Group's financial gap, improving efficiency and productivity, and the key risks associated with delivery. The report noted that the Plan was submitted with an overall deficit position of £24.4M (ULTH) and breakeven (LCHS). There was also a c6% CIP target (£65.0m) and a CIP stretch target (£5.7m) which equates to a total CIP requirement of £70.7m to achieve the current planned deficit position of £24.4m for the Group.

The report also outlined the three layers of delivery – i) large-scale transformation overseen by the committee, ii) cross-cutting targeted transformation for finance and performance, and iii) transactional items for PRMs. The Productivity, Improvement and Transformation Oversight Forum (PITOF) Group will oversee large-scale transformation, with updates provided to the Committee at varying intervals.

The Committee was provided with **reasonable assurance** by the update on the 2026/27 Annual Plan submission and the plan for its delivery.

The Group has received support from Maria Principe, the new Executive Director of Commissioning for the new Derbyshire, Lincolnshire and Nottinghamshire (DNL) ICB cluster for a plan to develop a specialist palliative care model across the cluster. The Committee was informed of planned steps by the Group and to work with commissioners to develop the role of the lead provider, the governance arrangements, and the approach for novating 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.

The Committee was provided with **reasonable assurance** on the early steps being implemented to develop a specialist PEOL care model for the DNL ICB cluster.

The Committee received a report which stated that as of January 2026, the Lincolnshire Lymphoedema Service had a caseload of 1,198 patients, with a waiting list stands at 94 patients. The report noted that the Service no longer had patients waiting over 52 weeks. This was a key recovery milestone, and the Group continued to take steps to continue making improvements.

The Committee was provided with **reasonable assurance** on the recovery trajectory of the Lymphoedema Service

<u>Assurances in respect of Objective 3b</u>:

a) Alliance Steering Group Upward Report

The Committee received a report which 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

i. Unplanned Care Integration: The work being undertaken to integrate the Urgent Community Response (UCR) service with the Virtual Wards and Home Visiting teams remained on track to be completed by the end of Q4. The Frailty at the Front Door Rapid Response Team has gone live, supporting earlier intervention.

ii. Left Shift: The transfer of specialties into the Alliance Care Group has been progressing with steps steadily, with budget mapping, team briefings and other activities to align teams were underway. Work was also being undertaken to utilise the Community Surgical Schemes as a tool for income generation, low-complexity surgery repatriation and engaging with GPs and the Lincolnshire Primary Care Network Alliance (LPCNA).

iii. Planned Care & Integrated Neighbourhood Working: The work being undertaken to develop the PEOL lead provider model is under Programme 3. Another workstream under this programme is 2026/27 transformation programme which includes the Newton Phase 2 programme. The next meeting of the Neighbourhood Health Board would also focus developing partner roles and responsibilities, the proposed Partnership Agreement.

iv. Health Inequalities: Efforts are focused on standardising ethnicity data capture, reviewing performance across teams, and ensuring health inequalities inputs are included in care group planning

The Committee was also updated on the output of a workshop organised for the Alliance Care Group's Steering Group to review and understand the parameters, definitions and expectations of the Group from the four programmes.

The Committee was provided with **reasonable assurance** on the outputs from the four Alliance Programmes.

Assurances in respect of Objective 3c:

a) Deep Dive - Digital Performance & Integration with NHS Arden and GEM (AGEM)
b) Digital Oversight Group Upward Report
c) Digital Planning & Delivery Update – EPR and EDMS

The Committee received a report which highlighted the successful transition of IT services for LCHS, the ICB and primary care from AGEM to a Group-provided model on 01 November 2025. This transfer included the transfer of staff into Group Digital Services and contracts, with performance and quality of the service provision having been improved since November 2025.

The report also highlighted steps to safely transition Lincolnshire Partnership NHS Foundation Trust's (LPFT) IT services from AGEM to the Group's Digital Services, and support for the AGEM CSU closure programme. The

support for the closure programme will involve taking over AGEM CSU's excellent Registration Authority (RA) team so they can improve the Group's RA function and generate income for the organisation.

The Committee was provided with **reasonable assurance** on the work to integrate service and functions from the closing AGEM CSU into the Group's Digital Services.

The Committee received the Digital Oversight Group (DOG) Upward Report with the highlights being that the rest of the acute Electronic Patient Record (EPR) Programme had advanced and was on target to be completed by the end of February 2026. There was a delay with the community EPR Programme due to differing interpretations of contract requirements between the supplier and LCHS. Work was being undertaken to resolve these differing interpretations.

The Committee was provided with **reasonable assurance** by the DOG Report.

The Digital Planning and Delivery- EPR & EDMS Report noted that the EPR programme is being delivered in three phases, with revised plans for the first two go-lives in October 2026 and April 2027, pending agreement with Nerve Centre. The final phase, involving PAS and outpatient operations, will be more complex due to patient services hub integration.

The Digital Planning and Delivery- EPR & EDMS Report stated that the Electronic Document Management System (EDMS) Implementation work had progressed with nine scanners having been installed across sites, with training underway and go-live scheduled for the end of March 2026. Clinical records will be scanned in clusters, with efforts to accelerate the timeline to clear space for Same Day Emergency Care (SDEC) and align with EPR rollout.

The Committee was provided with **reasonable assurance** by the Digital Planning and Delivery- EPR & EDMS Report.

Assurances in respect of Objective 3d:

a) Productivity, Improvement and Transformation Oversight Forum (PITOF) Group Upward Report

   The February 2026 PITOF meeting was stood down due to a lack of quoracy. The report was a synopsis of the reports which would have been reviewed had the meeting not been stood down.

   The Committee noted from the report that the Group was in a transitional period between the current PITOF work programme and the 2026/27 transformational programme. Work was also being undertaken to strengthen the PITOF framework.

Assurances in respect of other areas:

a) Board Assurance Framework 2025/26
b) Staff Story
c) Reporting Group Map
d) Committee Performance Dashboard
e) Risk Register
f) Policy Position

The Committee undertook a workshop for horizon scanning and to review the Board Assurance Framework (BAF) in detail as the Committee had been in place for a year. The session allowed the Committee to undertake reflections on progress over the past year and to focus on the development of the Committee and content of the BAF moving forward.

The Committee received a Staff Story which detailed the benefits which had accrued to the Transfer of Care Hubs since they adopted the OPTICA system. 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.

The Committee reviewed the January 2026 Performance Dashboard and noted that there were significant front door pressures due to 12-hour waits in January 2026. These 12-hours waits were mainly due to delays with onward transfers to acute sites and with transport from the East Midlands Ambulance Service (EMAS) NHS Trust.

The risk register was received with the Committee noting the movement in the risks presented.

The policy position was received and noted in respect of research policy documents.

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

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

a) None

4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

Rebecca Brown, Non-Executive Director

20 February 2026

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Strategy Delivery Q3 Assurance Report (2025/26)

Caring and building a healthier future for all

Meeting	*ELT*
Date of meeting	
Agenda item number	
Report title	*LCHG Strategy delivery Q3 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, Planning and Business Frameworks Support Lead*
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	*ELT is asked to:* *Review the Q3 report.* *Next steps submission at Integration Committee and Trust board to demonstrate delivery against LCHG 5-year strategy*

Assurance Rating Key:

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	*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 Q3 report provides reassurance against the delivery of the Trust Strategy. The overall assurance rating for Q3 is reasonable, indicating effective controls and appropriate assurances are mostly in place.

Strategic Pillar 1: Our Patients – Better Care

Key progress includes improvements in infection control, and patient experience. FFT scores are high (ULTH 88%, LCHS 89.97% - Q2 figures). Operational challenges persist in A&E (76.28% performance) and RTT (53.66%), with cancer pathway delays and diagnostics capacity issues. Financially, £41.9m in CIP savings were achieved. Estates and facilities show progress in safety, sustainability and maintenance.

Key actions include enhancing flow, UEC and Planned Care Improvement Programmes; expanding diagnostics; streamlining cancer pathways; and accelerating estates compliance. These actions support not only improving the quality of our care but are having measurable impact on our Cost Improvement Programme

Strategic Pillar 2: Our People – Better Opportunities

Training compliance exceeds 90%, and appraisal rates are exceeding target at ULTH and LCHS. The consultant workforce has increased by 5 WTE over the last 3 months. Staff recognition is high, with long service celebrations for 67 staff and Lincoln and Skegness CDCs won “CDC of the Year” at Building Better Healthcare Awards.

Risks include rising vacancy rates, high sickness absence, and WRES/WDES disparities.

Actions focus on recruitment, mandatory training support and inclusive leadership.

Strategic Pillar 3: Our Populations – Better Health

The Trust is driving major transformation initiatives, including optimising estates through the Open Space booking process, progressing infrastructure projects such as the Lincoln Endoscopy build and Community Diagnostic Centres, and implementing left shift care model redesign via the Alliance Steering Group. Digital and innovation capacity is being strengthened through the EPR programme reset, while sustainability goals are supported by Green Plans.

Challenges include fully implementing the Open Space booking process and resolving delays in the EPR project. Additional concerns involve maintaining momentum on estates projects and integrated care model delivery.

Actions include accelerating estates projects and prioritising EPR reset activities.

Conclusion

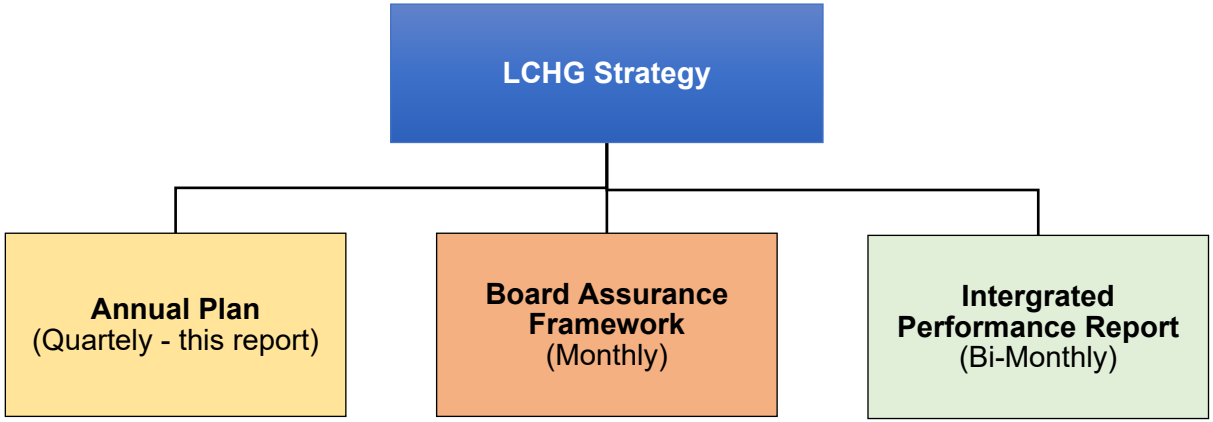
The Trust is making progress across all strategic pillars, with improvements in patient experience, workforce development, and transformation initiatives such as estates optimisation and care model redesign. However, operational pressures, digital delays, and workforce risks remain.

Focused actions on accelerating estates projects, completing the EPR reset, expanding diagnostics, and strengthening recruitment and inclusive leadership will be key to sustaining progress and delivering better outcomes for patients, people, and populations.

LCHG Strategy Delivery – Q3 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) – Q3 Strategic Assessment against delivery of ambitions set for 2025/26

Strategic Aim	Strategic Objective	What we will achieve in 2025/26?	Board Assurance Framework Strategic Risks
Patients: Timely, high quality and affordable care in the right place	1a: Improve patient safety, patient experience and deliver clinically effective care	Maximise safety of patients in our care, through learning from incidents, reducing incidents causing harm, improved IPC practices and reviewing external reports and assessments of our services Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas. Focus on improving the top three patient feedback themes: Communication, appointments and clinical practice	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny
	1b: Reduce waiting times for our patients	Utilise best practice from HVLC/GIRFT, deliver a number of planned care improvement programmes to maximise patient experience and flow to support elimination of 52 week wait and 18-week RTT Deliver a number of improvement programmes and projects focussed on unplanned care pathways, that deliver a reduction in A&E waiting times, and improve category 2 ambulance response times Better utilise our Community Diagnostics Centres and increase % of patients receiving diagnostic test within six weeks to support plans to address elective/ cancer backlogs and diagnostic waiting time	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm
	1c: Improve productivity and deliver financial sustainability	Robust CIP and productivity monitored through our LCHG Productivity, Improvement and Transformation Forum (PITOF) Embed a culture of Quality Improvement	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients
	1d: Provide modern, clean and fit for purpose care settings	Manage our backlog maintenance liability and deliver our capital programme Optimise property and space utilisation and improve functionality Improve our internal resilience across all services	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements, and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives

		Fully integrate group working across acute, community, private and system where possible	or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny

Key Highlights

1. Clinical Safety

Clinical safety remains a key priority for the Trust. Medication safety continues to be a concern, particularly regarding the omission of time-critical drugs. This is being addressed through the Patient Safety Incident Response Framework (PSIRF), with harm reduction identified as a priority workstream. Patient Safety Incident Investigation process has been reviewed with some identified gaps and areas to be strengthened through the new framework.

2. Infection Prevention and Control (IPC)

- Increasing number of Influenza A cases and active outbreaks across inpatient areas. Enhanced mask wearing guidance implemented across inpatient and outpatient settings to support the well-being of patients and staff. Paediatric flu and RSV levels remain low, and COVID-19 prevalence is minimal. Norovirus outbreaks are being actively managed.
- Staff Vaccination Programme – strong uptake and performance above national stretch targets for both acute and community services.
- Improved position in respect of water safety, for the positive detection of legionella and pseudomonas with augmented care flushing reported at 91%. A water safety plan under development will be shared with the Quality Committee.

3. Safeguarding

- **Adults**: Pressure ulcers and discharge planning remain recurring themes. In respect of Discharge Planning, we are working throughsupporting improved discharge, with proposed daily target for each ward and specialty.

4. Patient Experience

Patient experience metrics remain broadly positive.

- **Friends & Family Test**: ULTH reported 88% positive responses; LCHS 89.97% (Q2 figures).
- **Complaints**: investigated and responded to within agreed timescales (November - ULTH 74% against a target of 100%) (September - LCHS 2.58 against a target of 2.62 (Rate per 1000 WTE budgeted staff)). Patient stories are actively used in governance forums to support learning.

- **Duty of Candour**: DoC compliance remained high. Noted that no Never Events had been declared across the Group in 2025/26.

5. Clinical Effectiveness

Both Trusts maintained 100% participation in national clinical audits.
Mortality indicators improving – HSMR and SHMI remain in the *"as expected"* range and show month-on-month improvement.

6. Operational Performance

Urgent and Emergency Care

- Operational pressures across urgent and emergency care pathways remain significant. In November, the Trust recorded an overall A&E 4-hour performance of 76.28%, below the 78.0% target.
- Despite these pressures, there was an improvement in 12-hour trolley breaches, which reduced at M8 to 932 from 946. All breaches have undergone harm reviews, with no significant harm identified. Discharge lounges at Lincoln and Pilgrim continue to operate 24/7, supporting ED flow and timely transfers.
- Ambulance handover delays remain a concern, with 81.46% handovers delayed under 45 minutes. Late afternoon and evening surges continue to contribute to crowding.
- The non-elective length of stay (LOS) for November was 4.01 against a target of 4.50.

7. Elective and Cancer Pathways

- Referral to Treatment (RTT) performance remains below national expectations, with 53.66% of patients treated within 18 weeks in October. However, the Trust reported 105 patients waiting over 104 days in November, a decrease from October's 122, against a target of 10 and 43 patients waiting over 65 weeks in October, an increase of 19 from September's 24. The number of patients waiting over 52 weeks was 2,159 in October, an increase of 113 from September's 2,046. Significant improvement was expected for acute 52-week waits in November and December with recovery plans in place.
- The total waiting list stood at 68,810 at the end of October, an increase of 86 from September. Specialties with sustained pressure remain the focus of targeted recovery and transformation efforts.
- Diagnostics (DM01) significantly below target (61.7% vs 99%). Decline in diagnostic performance noted due to focus given to long waits, however, a plan is in development to recover the position.

8. Cancer pathway performance remains variable:

- Faster Diagnosis Standard (28-day): 75.25% in October, showing an increase from September and is below plan.
- 31-day first treatment: 91.5% (target: 96%).
- 62-day classic pathway: 63.3% (target: 85.39%).

- 104+ day waiters: Decreased to 105 patients.

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 8, the Group reported a £12.3m deficit, £2.4m adverse to plan; impacted by resident doctors' industrial action (£0.4m adverse), with further industrial action in December 2025. Delivered £41.9m in CIP savings, behind plan by £0.7m. The Group's cash position has deteriorated and stands at £25.7m, £13.6m lower than planned.

10. Estates and Facilities

The Trust continues to invest in estate safety and sustainability.

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

Strategic Aim 1 (Patients) Summary

The Trust remains focused on patient safety and quality, addressing medication safety through PSIRF and reinforcing infection control amid rising flu cases, supported by strong vaccination uptake and improved water safety. Safeguarding and patient experience are positive overall, though complaint response times need improvement. Clinical effectiveness is strong, but operational pressures persist in urgent care, elective recovery, and cancer pathways despite some progress. Financial performance is behind plan with a £12.3m deficit and CIP delivery slightly below target, while estates work continues with PPM review on track for January 2026.

Areas for Improvement & Actions:

Clinical & Patient Safety

- Reinforce PSIRF processes.
- Implement measures to prevent omissions of time-critical drugs.

IPC & Safeguarding

- Finalise and share the water safety plan.
- Implement Newtons discharge improvement plan with daily targets.
- Monitor and reduce pressure ulcers.

Patient Experience

- Improve complaint response timeliness.
- Continue using patient stories for governance learning.

Operational & Cancer Pathways

- Address ambulance handover delays and ED crowding.
- Sustain LOS improvement initiatives.
- Deliver recovery plans for elective backlog and diagnostics.
- Focus on specialties under pressure.
- Accelerate cancer pathway improvements.

Financial & Estates

- Intensify CIP delivery efforts.
- Mitigate impact of industrial action.
- Improve cash management.
- Complete PPM review as scheduled.
- Reduce helpdesk backlog to improve operational efficiency

Pillar 2 (Our People) – Q3 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

	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 October of 93.39% (ULTH) and for December of 92.40% (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 October 2025 were 82.14% (ULTH) and for November 2025 were 93.14% (LCHS)** against a target of 80.00%.
- Work taking place to rectify issue of incorrectly completed non-clinical Infection Prevention and Control module within mandatory training and assurance provided that this was an isolated issue. A referral would be made to the Quality Committee due to the potential risk.

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. **12% increase in response rates** for the 2025 NSS noted for both ULTH and LCHS compared to the previous year.
- **Medical workforce remains at the same level** over the last three months; however, we have seen a **further increase of 5 WTE in our consultant workforce.**

13. Nurture Compassionate and Diverse Leadership

- Culture and Leadership Programmes are in place across the group.
- 'Just Culture' principals – Launch of Being Fair Tool superseding the Just Culture Tool. Review taking place on what this means for the workstream.
- Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) – action plans continuing to be delivered. Limited assurance noted due to gaps in compliance, however, it was recognised that this would be resolved through the appointment of an EDI lead.
- Sickness absence for ULTH in October is 5.42% and in November for LCHS is 7.50% against Q3 target of 4.81%. Additional resource is being put in place to support the active and robust management of absence over the next 12 months.
- Turnover rate for October 2025 is 8.57% against a target of 9.00% (ULTH) and for November 2025 is 8.62% against a target* of 15.00% (LCHS). *The "target" level of 15% represents a ceiling to stay within.
- Vacancy rate for October 2025 is 5.80% against a target of 6.81% (ULTH). Monitoring will continue in 2025/26 to ensure recruitment to roles/services directly impacting patient care. Vacancy rate for November 2025 is 8.29% (LCHS) against a target of 6.99%.

14. Thanks, and Celebration

- **Long Service Awards** celebrated 67 LCHG clinical and support staff receiving certificates for 20, 30 or 40 years of NHS service.
- **Lincoln and Skegness CDCs won the CDC of the year award** presented at the Building Better Healthcare Awards in November 2025.

Strategic Aim 2 (People) Summary
The Trust is performing well in training and workforce development, with mandatory training and appraisal rates exceeding targets and positive engagement reflected in a 12% increase in staff survey responses. Leadership and culture programmes are progressing, including the review/launch of the “Being Fair” tool, though gaps in equality standards require an EDI lead. Workforce challenges remain, with sickness absence and vacancy rates above target, necessitating robust management. Despite these risks, turnover is stable, and staff recognition initiatives, including long service awards and national accolades, continue to strengthen morale.

Areas for Improvement & Actions:
Training, Development and Education

- Ensure protected time for staff to complete role-specific mandatory training.
- Provide targeted support for staff with ≤50% compliance.
- Rectify IPC module issue and refer to Quality Committee for assurance.

Continuously Improve and Innovate

- Maintain momentum on staff survey action plans and feedback loops.
- Support consultant workforce growth and medical staffing stability.

Nurture Compassionate and Diverse Leadership

- Embed “Being Fair” tool and review implications for Just Culture workstream.
- Deliver WRES and WDES action plans; expedite appointment of EDI lead.
- Strengthen sickness absence management with additional resources.
- Monitor vacancy and turnover rates; prioritise recruitment for patient care roles.

Pillar 3 (Our Populations) – Q3 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** Open Space booking process commenced in November 2025 in ULTH with a clear reduction in space wastage noted. Further work required to make the booking process fully effective. Implementation of the process in LCHS to follow. Lincoln Endoscopy build continues to move at pace. Progress also noted in respect of the Community Diagnostic Centres and Pilgrim car park.

16. Move from Prescription to Prevention

- **Alliance Steering Group**: New operating model for INTs endorsed, following Neighbourhood Health Board workshop; adoption of the 3-tier collaborative model (Planned, Unplanned, Resilient Communities) agreed at the Health & Wellbeing Board
- Alliance Steering Group sub-groups, with a clear 12-month delivery plan, on planned/unplanned care group transformation and left shift redesign programme all now in place and integrated neighbourhood teams being scoped (HI group well-established).
- **Integration of UCR, Virtual Wards & Home Visiting** remains on track for end-Q4 delivery.
- **Frailty at the Front Door** work embedded and linked with Medicine Care Group capacity.
- Data improvements strengthening understanding of demand and performance; early signs of improved activity flow.

17. Enhance our Digital and Research and Innovation Capacity

- **Electronic Patient Record (EPR) Project** rated ‘red’ due to programme having entered a reset phase during which the organisation of knowledge transfer for staff to gain a full understanding of the working of the EPR product would be enhanced to ensure successful conclusion of the transfer process.

- **Research and Innovation Group** – noted changes made to structure of the National Institute for Health and Care Research (NIHR), with budget now values based, split 50% baseline, 20% performance and 30% activity. A positive change for ULTH as funding no longer based on historical performance.

18. Drive Forward our Improvement, Efficiency and Sustainability Agenda

- Newton diagnostic work outcome received and noted indicative position offered in respect of INT working, reduction of duplication and improvement in patient experience.
- **Green Plans** approved and published in October as per national requirements.

Strategic Aim 3 (Populations) Summary
The Trust is progressing on key transformation priorities, including reducing space wastage through the new Estates Open Space booking process, advancing the Lincoln Endoscopy build, and developing Community Diagnostic Centres. Work is underway to shift care from prescription to prevention through Alliance Steering Group initiatives and integrated neighbourhood team planning. Digital transformation faces challenges, with the Electronic Patient Record (EPR) project rated 'red' and undergoing a reset phase to strengthen knowledge transfer. Research and innovation funding changes under NIHR present a positive outlook for ULTH. Efficiency and sustainability efforts continue, supported by Newton diagnostic work and the publication of Green Plans in line with national requirements.

Areas for Improvement & Actions:

Clinical Pathways & Estates
- Fully implement and optimise the Open Space booking process across ULTH and LCHS.
- Continue progress on Lincoln Endoscopy build, CDC development, and Pilgrim car park improvements.

Prevention-Focused Care
- Left Shift Programme Board established to oversee rapid transactional moves of care groups before end Q4 and will transition into oversight of transformational activities
- Deliver 12-month plans for planned/unplanned care transformation and left-shift redesign.
- Scope and establish integrated neighbourhood teams.

Digital & Innovation
- Resolve EPR project issues during reset phase to strengthen knowledge transfer.
- Adapt to NIHR funding changes and maximize performance-based opportunities.

Efficiency & Sustainability
- Productivity, Improvement and Transformation Programmes being scoped for 26/27 with a key focus on ensuring 'path to green' for all programmes.
- Deliver Green Plan commitments and monitor progress against national sustainability targets.

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	*3 March 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

Overall performance remains challenged across Urgent & Emergency Care, Planned Care recovery, and Workforce. While there are areas of stability in quality indicators and elective length of stay, sustained pressure in front door performance, 12-hour trolley waits, cancer standards, sickness absence, and vacancy rates present material operational and delivery risks.

Urgent & Emergency Care (UEC)
Key Concerns:
• 12-hour trolley waits remain significantly above trajectory (1,595 in January).
• EMAS handover <45 mins has deteriorated to 66.7% (target 95%).
• Under 4-hour performance at 71.94% (target 73%).
• Ongoing discharge delays impacting bed availability (up to 15% beds delayed).
Mitigations in place:
• Daily tactical reviews and harm reviews for 12hr waits.
• Rapid handover protocols and escalation areas activated.
• System-wide discharge improvement programme.

Planned Care & Cancer Recovery
Key Concerns:
• 104+ day waiters at 126 (target 10).
• 18-week performance at 54.13% (target 84.1%).
• 62-day cancer standard at 63.5% (target 85.39%).
• 52-week waiters reduced to 678 but remain above zero target.
Positive Indicators:
• Waiting list size reducing month-on-month.
• Elective LoS improved to 2.41 days (target 2.8).

Quality & Safety
Strengths:
• SHMI remains below target (106.05 vs 117).
• Falls performance within acceptable range.
Areas for Improvement:
• Category 3 pressure ulcers above target in Acute and Community.
• Complaint response timeliness at 77% (target 100%).

Workforce
Key Risks:
• Community sickness at 7.23% (target 4.81%), increasing trend.
• Community vacancy rate at 9.48% (target 6.99%).
• Acute vacancies at 6.5%.
Stability Indicators:
• Mandatory training compliance above 90% across organisations.
• Turnover reducing in both Acute and Community services.

Overall Assessment

The principal risks relate to sustained UEC pressure, discharge delays, cancer pathway recovery, and workforce capacity (particularly sickness absence). While quality indicators remain broadly stable, operational performance gaps require continued Board-level oversight and system-wide intervention.
Immediate focus areas for the Board: UEC flow and discharge, cancer recovery trajectory, and workforce sickness reduction.

Summary of Changes

- Committee dashboard changelog created and circulated

Next Steps

- Review of targets

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 M10

Lincolnshire Community and Hospitals NHS Group

Overall Summary

FPC	Integration Committee Scorecard	People Committee Dashboard	Quality Committee Report
2.17	2.27	2.03	2.10

Finance & Performance

Community - Unplann…	Community - Front D…	Acute - Front Door	Acute - Planned	Acute - Unplanned	Community - Planned
1.77	2.43	2.90	2.50	2.60	1.77

Integration

Community - Unplanned	Acute - Front Door	Acute - In Hospital	Community - Planned
2.08	2.50	2.56	2.15

People

Vacancies	Staffing Le…	Staff Traini…	Staff Healt…	Job Planning	Policies & …	Recruitment	Internation…	Employee …	Sickness …
2.08	2.25	1.83	2.00	2.00	2.00	2.00	2.00	2.00	2.00

Quality

Clinical Effectiveness	Patient Safety	Patient Experience
2.08	2.06	2.25

Range	Colour	Description
1.00 - 2.00	Green	Performing Well/On Track
2.01 - 2.99	Warm Amber	Slightly Below Expectations
3.00	Burnt Orange	Performance Concern
3.01 - 4.00	Red	Underperforming

Group Board M8

Lincolnshire Community and Hospitals NHS Group

Acute - Quality	Community -...	Acute - Work...	Community -...	Community -...	Acute - Fron...	Acute - Plan...	Acute - Unpl...	Community -...
1.90	2.00	1.80	2.50	1.88	2.79	2.50	1.50	2.00

Metrics Out of Range

Section Name	Org Name	Metric Name	Value	Target	LCHG Score
Community - Workforce	Lincolnshire Community Health Services	Workforce - Sickness Rate	7.23%	4.81%	3.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Vacancy Rate	9.48%	6.99%	3.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - % EMAS Conveyance Delayed <45 mins	66.70%	95.00%	3.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - >12hr Trolley Waits	1595	0	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 104+ Day Waiters	126	10	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	77.00%	100.00%	2.50
Acute - Quality	United Lincolnshire Teaching Hospitals	Acute - Pressure Ulcers category 3	8.00	4.30	2.50
Community - Quality	Lincolnshire Community Health Services	Complaints - Rate per 1000 WTE	3.93	2.62	2.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Overall Compliance	91.53%	90.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - % Triage Data Not Recorded	0.41%	0.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	Acute - Under 4 hour performance	71.94%	73.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - 15 Minute Ambulance Handover	90.16%	95.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - 15 Minute Triage Compliance	92.93%	95.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - Monthly 4 Hour Waits	96.35%	98.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 18 week incompletes	54.13%	84.10%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 28 days faster diagnosis	72.85%	75.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 31 day first treatment	88.90%	96.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 52 Week Waiters	678	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 62 day classic	63.50%	85.39%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 65 Week Waiters	7	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Waiting List Size	66866	58965	2.50
Community - Planned	Lincolnshire Community Health Services	52 Week Waits %	99.95%	100.00%	2.50

Information on Scoring Methodology

Report Performance Dashboard

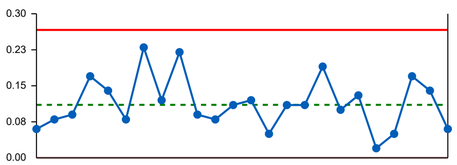
Lincolnshire Community and Hospitals NHS Group

Acute - Quality

Acute - Falls per 1000 bed days resulting in moderate, severe

United Lincolnshire Teaching Hospitals — Target: 0.19

Activity Volume

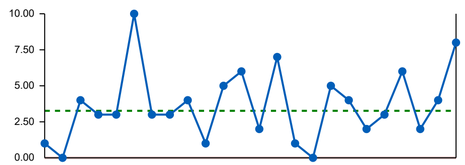


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
0.12	0.05	0.11	0.11	0.19	0.10	0.13	0.02	0.05	0.17	0.14	0.06

Acute - Pressure Ulcers category 3

United Lincolnshire Teaching Hospitals — Target: 4.30

Activity Volume

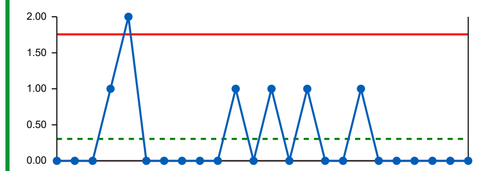


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2.00	7.00	1.00	0.00	5.00	4.00	2.00	3.00	6.00	2.00	4.00	8.00

Acute - Pressure Ulcers category 4

United Lincolnshire Teaching Hospitals — Target: 1.30

Activity Volume

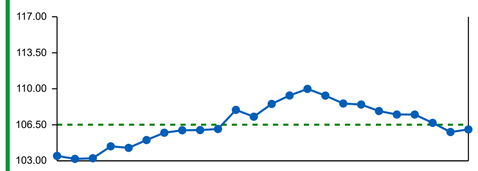


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00

Acute - Summary Hospital Mortality Indicator (SHMI) (rolling y

United Lincolnshire Teaching Hospitals — Target: 117.00

Activity Volume

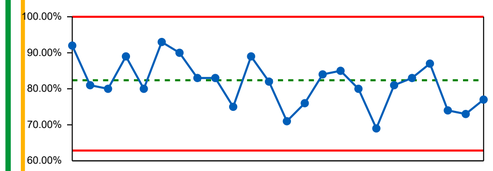


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
108.53	109.35	109.99	109.34	108.57	108.47	107.84	107.50	107.50	106.69	105.80	106.05

Acute - Complaints investigated and responded to within agre

United Lincolnshire Teaching Hospitals — Target: 100.00%

Activity Volume



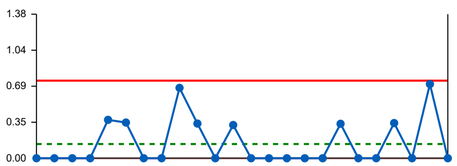
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
71.00%	76.00%	84.00%	85.00%	80.00%	69.00%	81.00%	83.00%	87.00%	74.00%	73.00%	77.00%

Community - Quality

Community Hospital Injurious Falls per 1000 OBDs

Lincolnshire Community Health Services — Target: 1.38

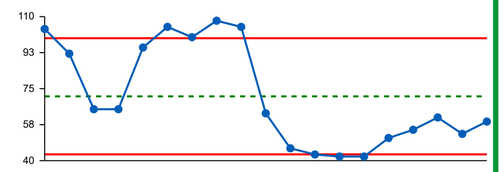
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
0.00	0.00	0.00	0.00	0.00	0.33	0.00	0.00	0.34	0.00	0.71	0.00

Quality - Pressure Ulcers Category 3

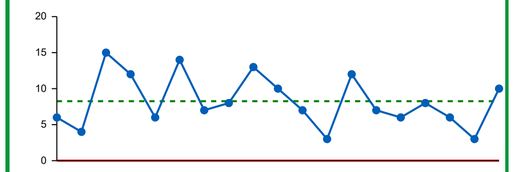
Lincolnshire Community Health Services



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
108	105	63	46	43	42	42	51	55	61	53	59

Quality - Pressure Ulcers Category 4

Lincolnshire Community Health Services

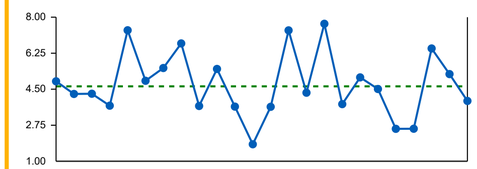


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
8	13	10	7	3	12	7	6	8	6	3	10

Complaints - Rate per 1000 WTE

Lincolnshire Community Health Services — Target: 2.62

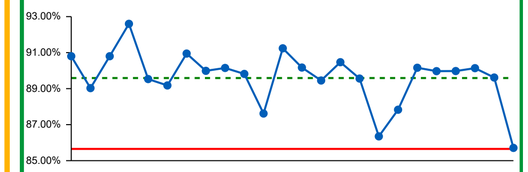
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
3.65	7.36	4.33	7.68	3.77	5.08	4.51	2.58	2.58	6.48	5.24	3.93

Friends & Family Test

Lincolnshire Community Health Services



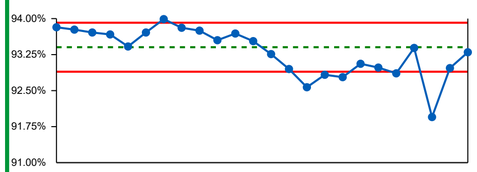
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
90.17%	89.45%	90.47%	89.56%	86.35%	87.83%	90.16%	89.97%	89.98%	90.14%	89.62%	85.71%

Acute - Workforce

Acute - Overall percentage of completed mandatory training

United Lincolnshire Teaching Hospitals — Target: 90.00%

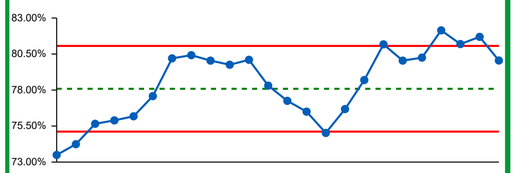
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
93.26%	92.95%	92.57%	92.83%	92.78%	93.06%	92.98%	92.86%	93.39%	91.95%	92.97%	93.30%

Acute - Staff Appraisals

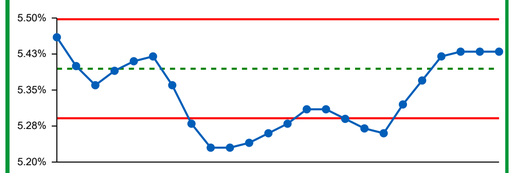
United Lincolnshire Teaching Hospitals



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
77.25%	76.50%	75.02%	76.68%	78.69%	81.17%	80.04%	80.25%	82.14%	81.19%	81.69%	80.05%

Acute - Sickness Absence

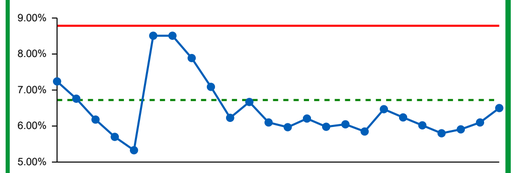
United Lincolnshire Teaching Hospitals



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
5.28%	5.31%	5.31%	5.29%	5.27%	5.26%	5.32%	5.37%	5.42%	5.43%	5.43%	5.43%

Acute - Number of Vacancies

United Lincolnshire Teaching Hospitals

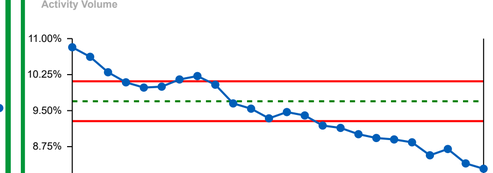


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
5.97%	6.21%	5.98%	6.05%	5.85%	6.47%	6.24%	6.02%	5.80%	5.91%	6.10%	6.50%

Acute - Staff Turnover

United Lincolnshire Teaching Hospitals — Target: 9.00%

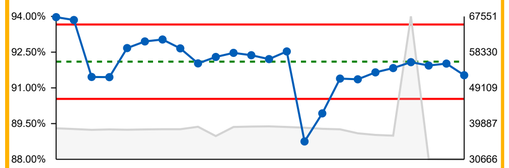
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
9.47%	9.40%	9.19%	9.14%	9.01%	8.93%	8.90%	8.84%	8.57%	8.70%	8.40%	8.29%

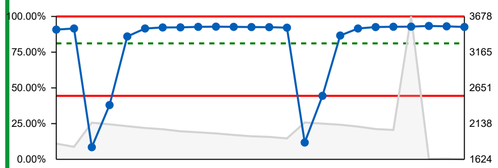
Community - Workforce

Workforce - Overall Compliance
Lincolnshire Community Health Services — **Target: 90.00%**
Activity Volume



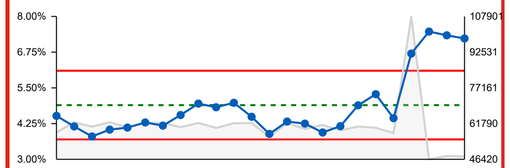
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
92.21%	92.53%	88.75%	89.93%	91.39%	91.36%	91.65%	91.83%	92.08%	91.94%	92.02%	91.53%

Workforce - Appraisals
Lincolnshire Community Health Services — **Target: 80.00%**
Activity Volume



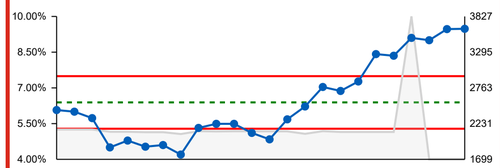
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
92.50%	92.16%	11.80%	44.45%	86.61%	91.60%	92.57%	92.82%	92.88%	93.38%	93.09%	92.67%

Workforce - Sickness Rate
Lincolnshire Community Health Services — **Target: 4.81%**
Activity Volume



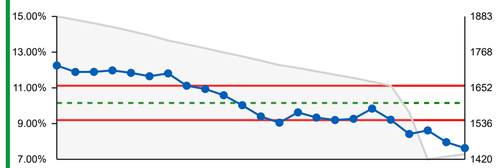
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
3.89%	4.32%	4.25%	3.94%	4.16%	4.89%	5.28%	4.44%	6.70%	7.47%	7.34%	7.23%

Workforce - Vacancy Rate
Lincolnshire Community Health Services — **Target: 6.99%**
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
4.84%	5.68%	6.22%	7.04%	6.87%	7.27%	8.42%	8.35%	9.10%	9.00%	9.47%	9.48%

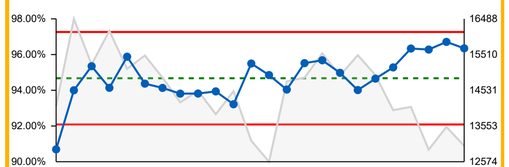
Workforce - Turnover
Lincolnshire Community Health Services — **Target: 15.00%**
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
9.40%	9.05%	9.63%	9.34%	9.20%	9.27%	9.84%	9.22%	8.42%	8.62%	7.96%	7.63%

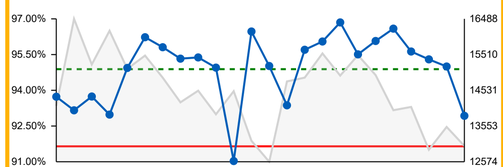
Acute - Front Door

UTC - Monthly 4 Hour Waits
Lincolnshire Community Health Services — **Target: 98.00%**
Activity Volume



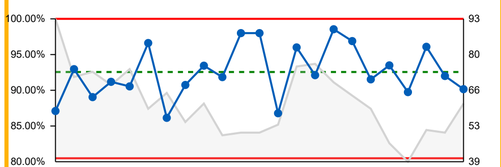
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
94.85%	94.04%	95.52%	95.68%	94.98%	94.01%	94.65%	95.28%	96.34%	96.28%	96.71%	96.35%

UTC - 15 Minute Triage Compliance
Lincolnshire Community Health Services — **Target: 95.00%**
Activity Volume



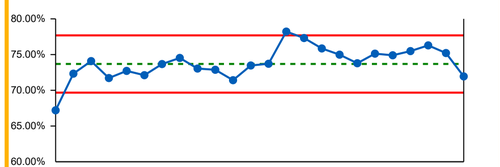
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
95.02%	93.37%	95.70%	96.05%	96.85%	95.51%	96.07%	96.59%	95.63%	95.30%	95.00%	92.93%

UTC - 15 Minute Ambulance Handover
Lincolnshire Community Health Services — **Target: 95.00%**
Activity Volume



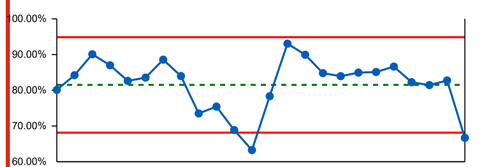
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
98.00%	86.79%	96.00%	92.11%	98.55%	96.88%	91.53%	93.48%	89.74%	96.08%	92.00%	90.16%

Acute - Under 4 hour performance
United Lincolnshire Teaching Hospitals — **Target: 73.00%**
Activity Volume



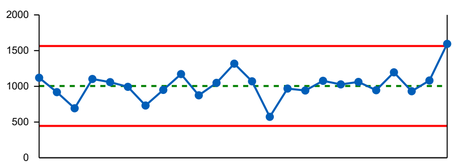
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
73.72%	78.21%	77.32%	75.86%	74.98%	73.78%	75.13%	74.90%	75.48%	76.28%	75.21%	71.94%

Acute - % EMAS Conveyance Delayed <45 mins
United Lincolnshire Teaching Hospitals — **Target: 95.00%**
Activity Volume



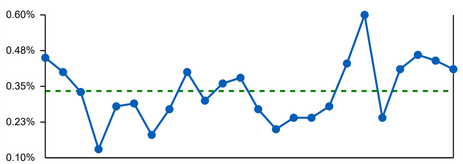
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
78.35%	93.07%	89.94%	84.80%	83.93%	84.94%	85.11%	86.64%	82.27%	81.46%	82.74%	66.70%

Acute - >12hr Trolley Waits
United Lincolnshire Teaching Hospitals — **Target: 0**
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1070	573	969	942	1077	1027	1061	946	1196	932	1081	1595

Acute - % Triage Data Not Recorded
United Lincolnshire Teaching Hospitals — **Target: 0.00%**
Activity Volume



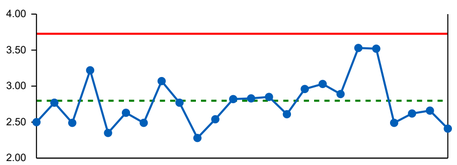
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
0.27%	0.20%	0.24%	0.24%	0.28%	0.43%	0.60%	0.24%	0.41%	0.46%	0.44%	0.41%

Acute - Planned

Acute - Hospital Average LoS (Elective)

United Lincolnshire Teaching Hospitals — **Target: 2.80**

Activity Volume

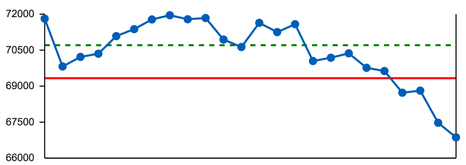


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2.83	2.85	2.61	2.96	3.03	2.89	3.53	3.52	2.49	2.62	2.66	2.41

Acute - Waiting List Size

United Lincolnshire Teaching Hospitals — **Target: 58965**

Activity Volume

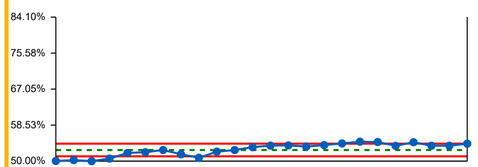


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
71248	71582	70044	70185	70366	69763	69630	68724	68810	67474	66866	

Acute - 18 week incompletes

United Lincolnshire Teaching Hospitals — **Target: 84.10%**

Activity Volume

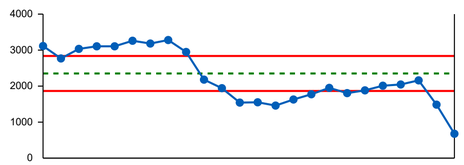


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
53.72%	53.46%	53.80%	54.18%	54.60%	54.54%	53.62%	54.47%	53.66%	53.65%	54.13%	

Acute - 52 Week Waiters

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

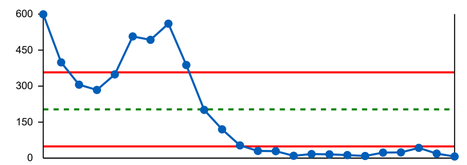


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1461	1629	1775	1951	1805	1882	2012	2046	2159	1487	678	

Acute - 65 Week Waiters

United Lincolnshire Teaching Hospitals — **Target: 0**

Activity Volume

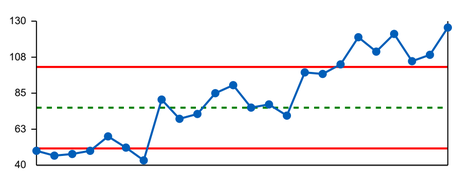


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
29	10	17	16	13	9	23	24	43	19	7	

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals — **Target: 10**

Activity Volume

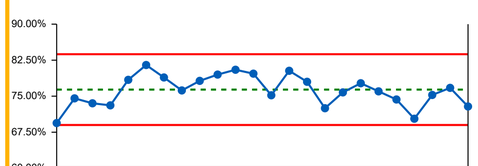


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
76	78	71	98	97	103	120	111	122	105	109	126

Acute - 28 days faster diagnosis

United Lincolnshire Teaching Hospitals — **Target: 75.00%**

Activity Volume

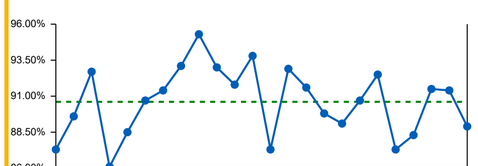


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
80.30%	78.00%	72.50%	75.80%	77.70%	76.00%	74.32%	70.30%	75.25%	76.74%	72.85%	

Acute - 31 day first treatment

United Lincolnshire Teaching Hospitals — **Target: 96.00%**

Activity Volume

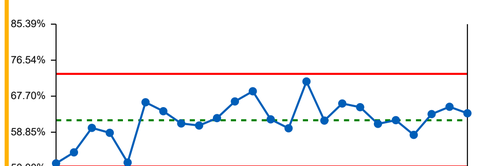


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
92.90%	91.60%	89.80%	89.10%	90.70%	92.50%	87.30%	88.30%	91.50%	91.40%	88.90%	

Acute - 62 day classic

United Lincolnshire Teaching Hospitals — **Target: 85.39%**

Activity Volume



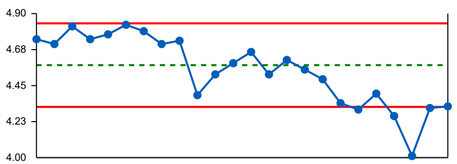
Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
59.80%	71.30%	61.70%	65.90%	65.00%	60.90%	61.80%	58.20%	63.30%	65.10%	63.50%	

Acute - Unplanned

Acute - Average LoS (Non Elective)

United Lincolnshire Teaching Hospitals — **Target: 4.50**

Activity Volume

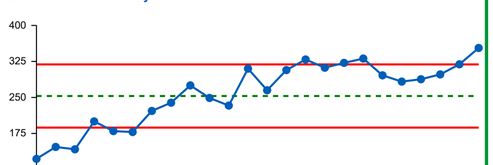


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
4.66	4.52	4.61	4.55	4.49	4.34	4.30	4.40	4.26	4.01	4.31	4.32

Community - Planned

LCHS - LoS Reduction

Lincolnshire Community Health Services

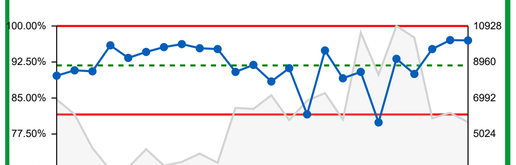


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
265	307	329	312	322	331	296	283	288	298	319	353

18 Week Wait

Lincolnshire Community Health Services — **Target: 65.00%**

Activity Volume

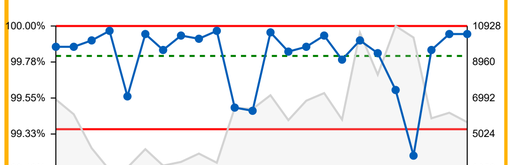


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
88.46%	91.21%	81.59%	94.91%	89.12%	90.44%	79.93%	93.16%	90.02%	95.21%	97.06%	97.00%

52 Week Waits %

Lincolnshire Community Health Services — **Target: 100.00%**

Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
99.96%	99.84%	99.87%	99.94%	99.79%	99.91%	99.83%	99.60%	99.19%	99.85%	99.95%	99.95%

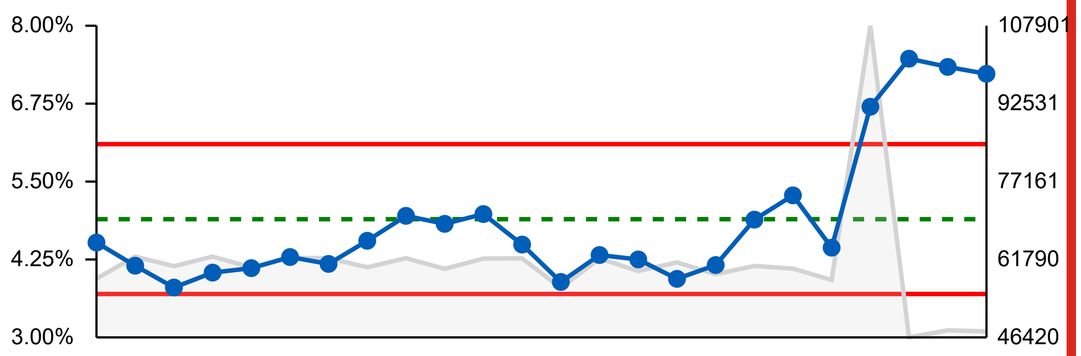
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Workforce - Sickness Rate

Lincolnshire Community Health Services **Target: 4.81%**

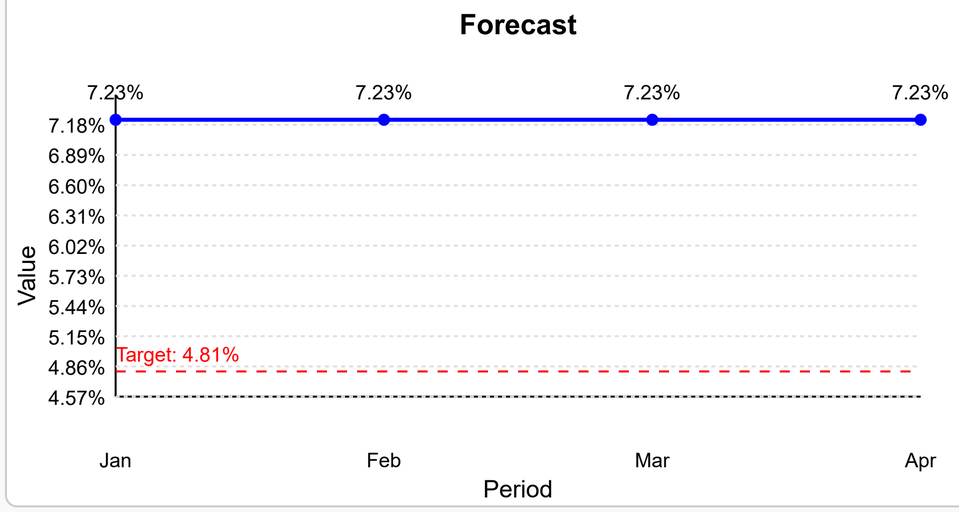
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
3.89%	4.32%	4.25%	3.94%	4.16%	4.89%	5.28%	4.44%	6.70%	7.47%	7.34%	7.23%

Overall sickness is sitting at 7.23%, a slight reduction in comparison to the previous month where it was sitting at 7.34% It's worth noting that the CIPD and Simplyhealth research found that UK employees were absent an average of 9.4 days over the past year – the highest rate seen in 15 years. The research found that mental ill health is the leading cause of long-term absence and the second most common cause of short-term absence. The research also found that stress is a significant factor for both short-term and long-term absences.

To support with the increased concerns ongoing absences summits are being held to offer additional support to leaders as we continue to navigate the challenges and opportunities around absence across the organisation. The team and HR are meeting with the new Absence Manager for the group, Nicola Dobson, to discuss how we can all support where possible and ensure it remains a key focus and high priority. Operational teams have a sickness reduction plan in place to supported by HR, this includes all senior leaders undertaking the mental health first aid course



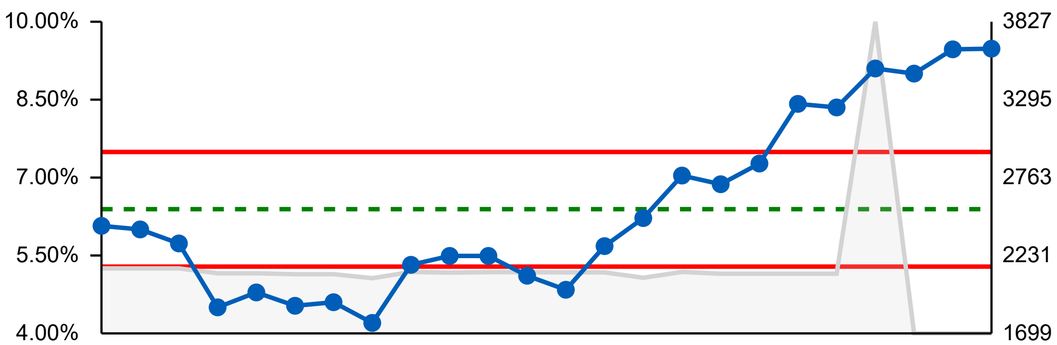
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Workforce - Vacancy Rate

Lincolnshire Community Health Services **Target: 6.99%**

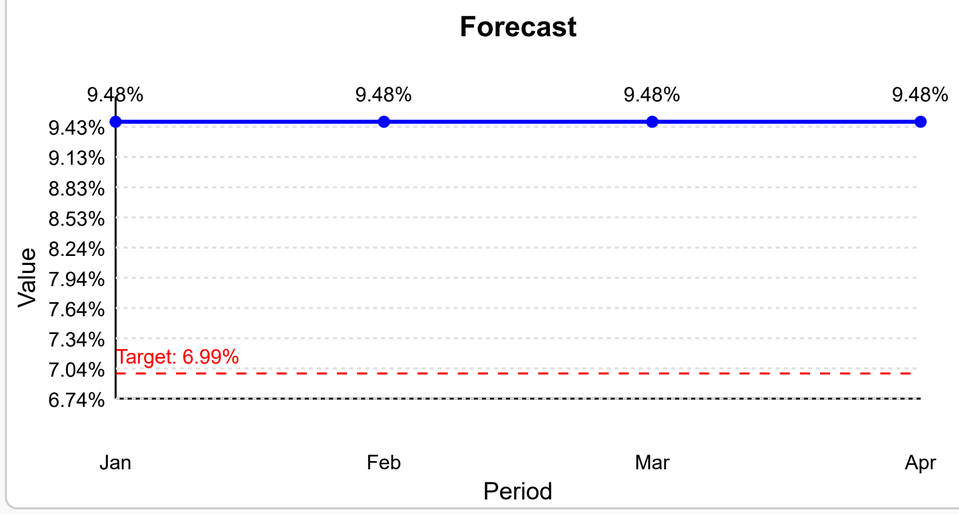
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
4.84%	5.68%	6.22%	7.04%	6.87%	7.27%	8.42%	8.35%	9.10%	9.00%	9.47%	9.48%

No comment Available

No comment Available



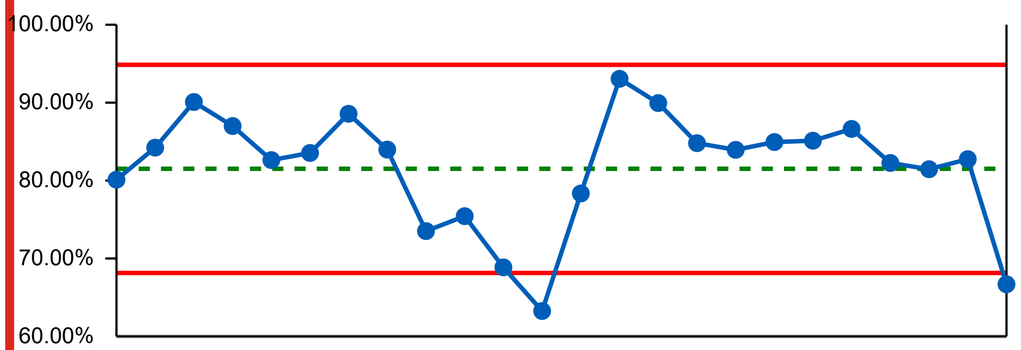
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - % EMAS Conveyance Delayed <45 mins

United Lincolnshire Teaching Hospitals **Target: 95.00%**

Activity Volume

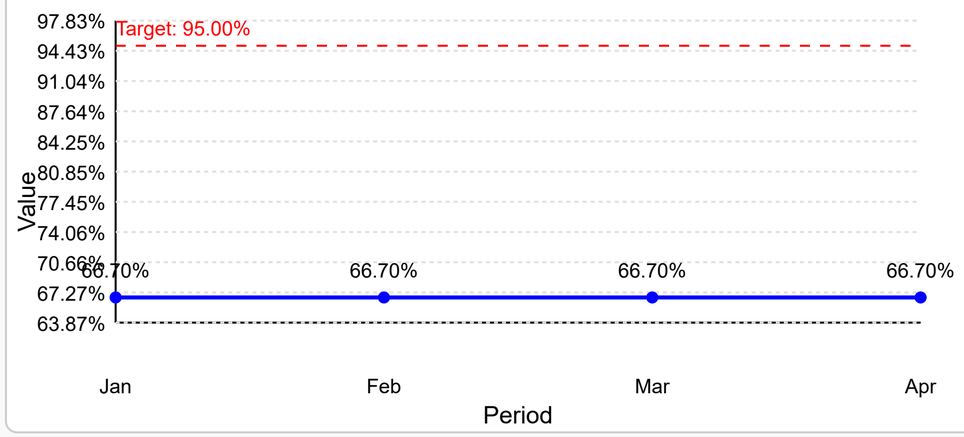


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
78.35%	93.07%	89.94%	84.80%	83.93%	84.94%	85.11%	86.64%	82.27%	81.46%	82.74%	66.70%

The pattern of conveyance and prioritisation of clinical need contributes to the delays. Increased conveyances continue to profile into the late afternoon, and evening coincides with increased 'walk in' attendances causing a reduce footprint to respond to timely handover. An increasing number of category 1 and 2 patients being conveyed. Inadequate flow and sub-optimal discharges continue to result in the emergency departments being unable to completely deescalate due to a few patients waiting for admission, although this number reduced.

All ambulances approaching 30 minutes without a plan to off load are escalated to the Clinical Site Manager in hours and SOC out of hours. Daily communication with EMAS crews to sign post to alternative pathways and reduce conveyances to the acute setting. Active monitoring of the EMAS inbound screen to ensure the departments are ready to respond. Rapid handover protocol, designated escalation areas have been identified/confirmed to assist in reducing delays in handover. Plus 1/2 Process active to alleviate pressure/capacity in ED.

Forecast



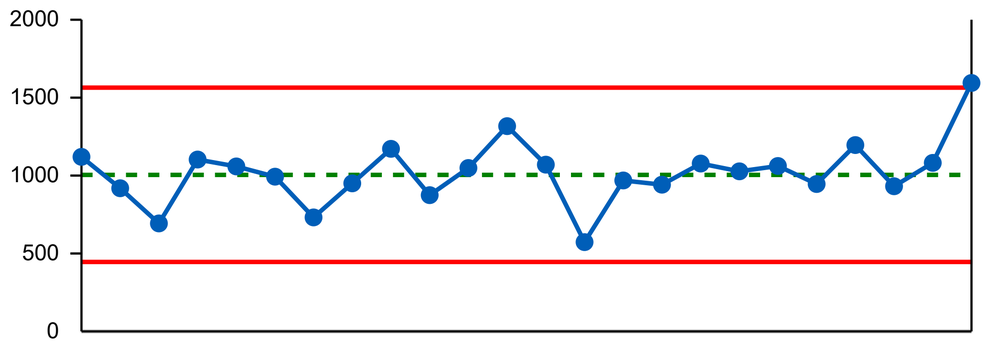
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - >12hr Trolley Waits

United Lincolnshire Teaching Hospitals **Target: 0**

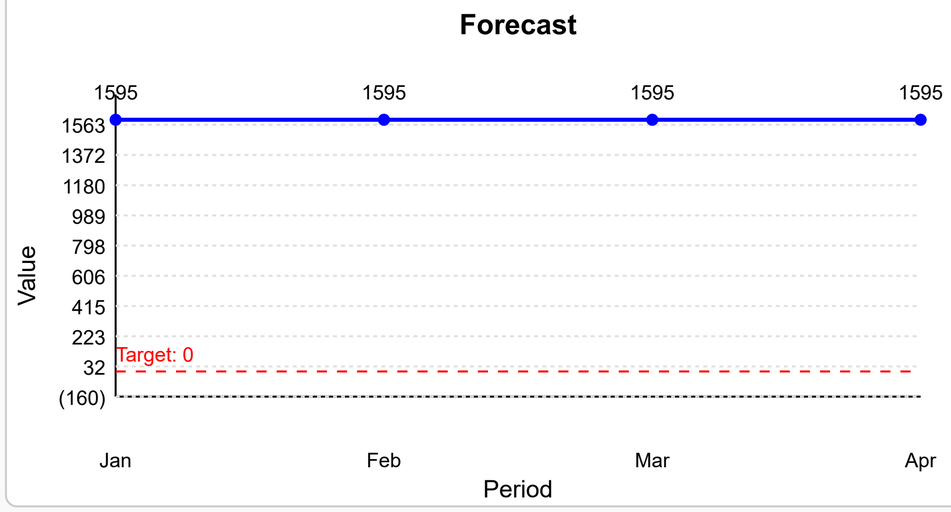
Activity Volume



Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1070	573	969	942	1077	1027	1061	946	1196	932	1081	1595

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.



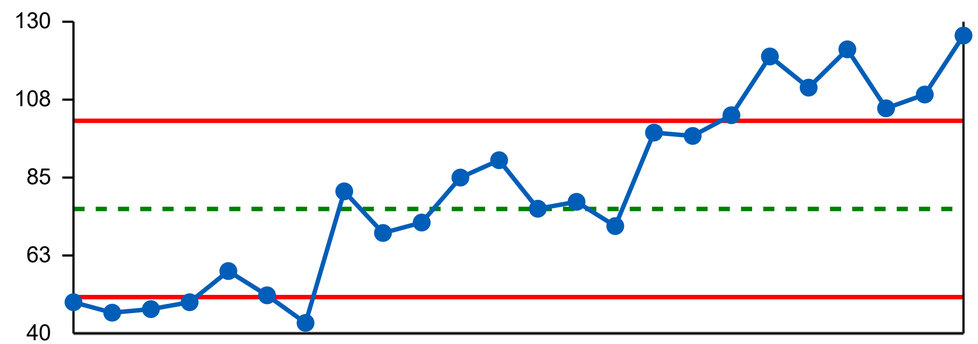
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals **Target: 10**

Activity Volume

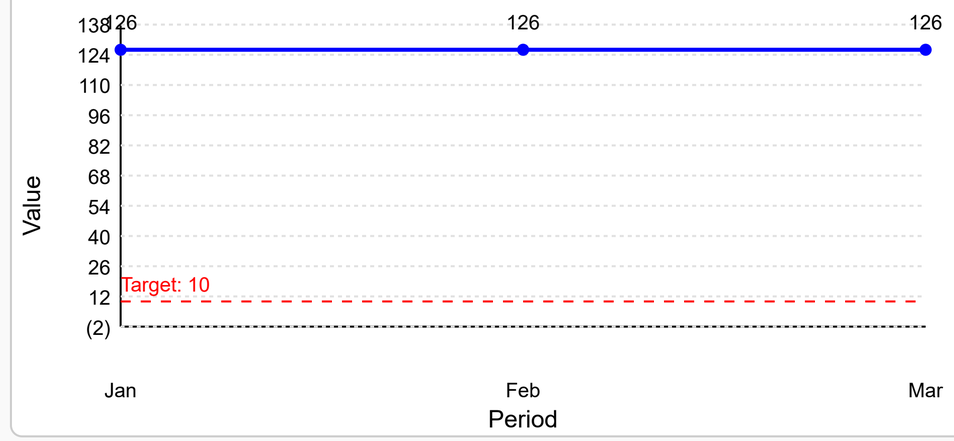


Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
76	78	71	98	97	103	120	111	122	105	109	126

The impact of ongoing pathway, staffing and capacity challenges. Patients not willing to travel to where our service and / or capacity is available. Reduced OP, diagnostic and theatre capacity across the Trust, all Specialties vying for additional sessions. Managing backlogs significantly in excess of pre-COVID levels for Colorectal, Upper GI, Urology, Head & Neck, Gynaecology, and Lung. Approximately 16.67% of these patients require support from the Pre-Diagnosis CNS as they have mental or social care needs that have the potential to significantly impact on the length of their pathway.

Intensive Support Meetings in place to support Colorectal, Urology, Head & Neck, Lung, Upper GI, Skin, Gynae and Breast recovery. Please also see Actions on accompanying pages.

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	*3 March 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 Group Board is asked to:* • *Review the content of the report. There are no further escalations at this time.*

Assurance Rating Key:

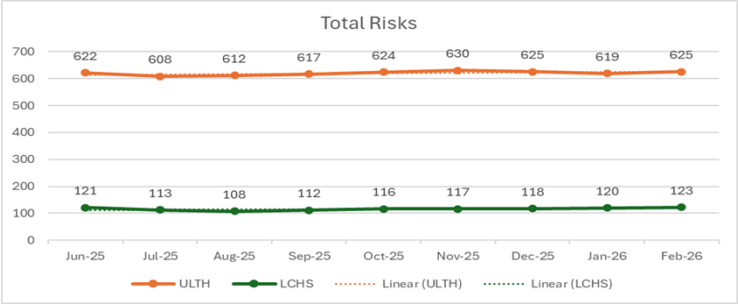
Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are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

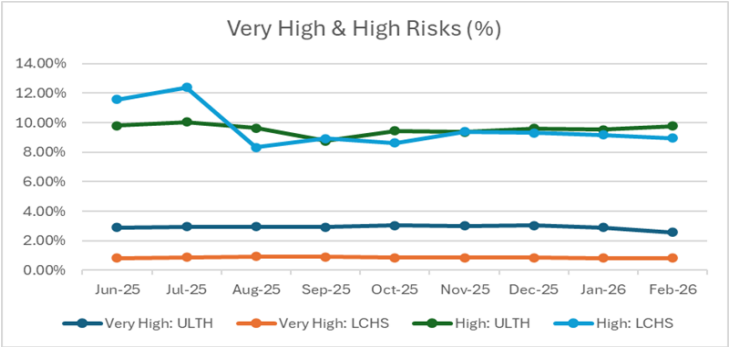
Risk movement over time:

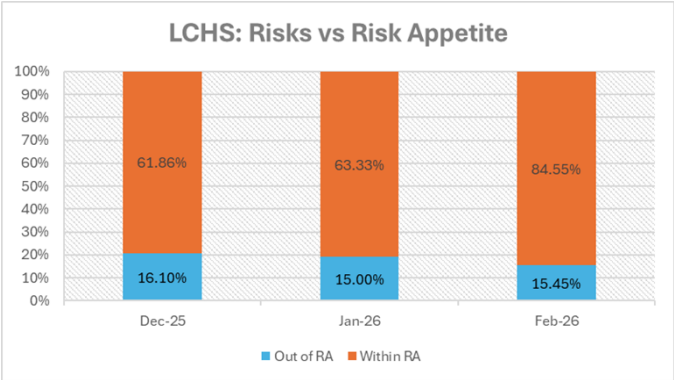
- As of 23 February 2026, there are 748 (LCHS 123 and ULTH 625) risks in total.
- This is an increase of 5 since last the last report.
- The chart demonstrates the split between ULTH and LCHS



Very high / High risk movement:

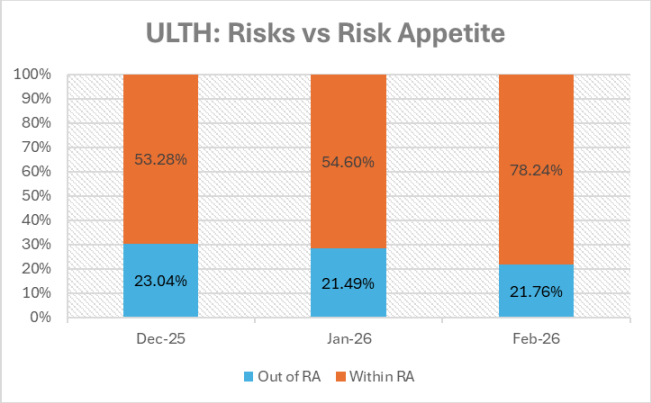
- There are 17 (2%) risks considered to be **very high** (20-25) (see appendix A for full detail)
  - LCHS: 1 (1%)
  - ULTH: 16 (3%)
  - The chart demonstrates a decrease of 3 **very high** risks since the previous report
- There are 72 (10%) risks considered to be **high** (15-20) (see appendix B for full detail)
  - LCHS: 11 (9%)
  - ULTH: 61 (10%)
  - The chart demonstrates decreased LCHS high risks from 12% in July 2025 to 9% (a decrease of 3 **high** risks).





Risks vs Risk Appetite[1]:

- Risk versus the Group's risk appetite was reported for the first time in December 2025. This will feature more prominently in this report in future iterations as the risk appetite profile over time is analysed and reported.
- The proportion of risks reported that **exceed** the risk appetite established for LCHS is lower than ULTH:
  - LCHS: 15%
  - 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 January 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 the 23 February 2026, there are 748 (LCHS 123 and ULTH 625) risks in total.
- This is **an increase of 5** since the January 2026 report.
- Of the 748 risks, there are 89 (12%) risks considered to be **high** or **very high**, scoring 15 – 25. The full lists are available in **Appendix A and B.** These are broken down by organisation as follows:
- **LCHS:** Very high (20-25): 1 (same as previous report):
    - **Quality Committee (n=1):**
    - 403 - Children SLT Therapy Treatment Delays
- **ULTH:** Very high (20-25): 16 (a decrease of -3 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=4; same as previous report):
    - 4844 – Staffing levels requiring an increase in Pharmacy to provide 7-day dispensing service
    - 4996 - Consultant workforce capacity (Haematology)
    - 4997 – Service configuration (Haematology)
    - 5093 – Procurement service staffing levels (Pharmacy)
    - **Finance and Performance Committee:** (n=3; a decrease of -3 since the 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

      Following Risk Confirm & Challenge meetings in December 2025 and January 2026, the following risk level reductions were approved:

        - 4657 - Compliance with Subject Access Requests **reduction in score from 5x4:20 Very High Risk to 3x4:16 Moderate Risk –** due to improvements in the process and performance greatly improved, measured by fewer complaints to the Trust and ICO.
        - 4839 - Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG) – **Very High Risk was agreed for closure** - all staff are now in post and fully compliant with relevant training requirements.
        - 5447 - Cancellation of elective lists due to lack of theatre staff **reduction in score from 5x4:20 Very High Risk to 4x4:16 High Risk –** due to an improvement in both the availability of staff and training competency reflecting in the reduction of the number of cancellations.
    - **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 123 risks, 19 are out of the risk appetite set (an increase of 2 since Jan-26).
- **ULTH:** Of the 625 risks, 136 are out of the risk appetite set (a decrease of 8 since Jan-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	25	13	148	90
1a (ii): Patient Experience	**Open:** Prepared to accept risks up to 12	8	0	31	5
1a (iii): Clinically Effective Care	**Open:** Prepared to accept risks up to 12	7	0	15	0
1b: Reduce waiting times for our patients	**Open/Cautious:** Prepared to accept risks rated to 10-12	4	1	13	4
1c: Improve productivity and deliver financial sustainability	**Open:** Prepared to accept risks rated to 12	13	1	67	5
1d: Provide modern, clean and fit for purpose care settings	**Open:** Prepared to accept risks rated to 12	14	2	91	12
2a: Enable our people to fulfil their potential through training, development and education	**Open:** Prepared to accept risks rated to 12	6	2	14	10
2b: Empower our people to continuously improve and innovate	**Hungry:** Prepared to accept risks rated as 15/16	4	0	12	3
2c: Nurture compassionate and diverse leadership	**Open:** Prepared to accept risks rated to 12	1	0	8	0
2d: Recognising our people through thanks and celebration	**Hungry:** Prepared to accept risks rated as 15/16	0	0	1	0
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	**Open:** Prepared to accept risks rated to 12	4	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	11	0	77	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).**

NB: Full details of all risks outside of risk appetite are reported in **Appendix D.**

2.3 The LCHG Risk Register Confirm and Challenge Group continues to meet monthly, reviewing all High and Very High risks, as well as receiving presentations from clinical and corporate areas on a rotational basis to enable constructive feedback to be provided.

3. Group Risk Profile:

3.1: Lincolnshire Community Health Services NHS Trust

Risk profile: This month compared to last report:

This month vs. last month	Number of risks	Very low (1-3)	Low (4-6)	Moderate (8-12)	High (15-16)	Very high (20-25)
Feb – 2026	123	**5** (4%)	**36** (29%)	**70** (57%)	**11** (9%)	**1** (1%)
Dec – 2025	118	**4** (3%)	**37** (31%)	**65** (56%)	**11** (9%)	**1** (1%)

- The number of risks has increased by 5 compared to the previous report.
- 1 risk is scored 'Very High'. There is no change from the previous report.
- 11 risks are scored as 'High'. There is no change 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	1	1	0	**4**
	Quite likely (4) 71-90% chance	1	5	12	9	0	**27**
	Reasonably likely (3) 31-70% chance	2	5	18	11	1	**37**
	Quite unlikely (2) 10-30% chance	0	6	21	16	6	**49**
	Extremely unlikely (1) <10% chance	0	0	3	2	1	**6**
	Total	**3**	**18**	**55**	**39**	**8**	**123**

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)
Feb – 2026	625	**45** (7%)	**158** (25%)	**345** (55%)	**61** (10%)	**16** (3%)
Dec – 2025	625	**46** (7%)	**156** (25%)	**344** (55%)	**60** (10%)	**19** (3%)

- There is no change in the number of risks compared to the previous report.
- 16 risks are scored as 'Very High'. This is a decrease of 3 from the previous report.
- 61 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	10	13	14	0	**38**
	Quite likely (4) 71-90% chance	2	32	73	46	2	**155**
	Reasonably likely (3) 31-70% chance	2	40	98	73	2	**215**
	Quite unlikely (2) 10-30% chance	17	24	72	48	11	**172**
	Extremely unlikely (1) <10% chance	8	9	9	13	6	**45**
	Total	**30**	**115**	**265**	**194**	**21**	**625**

4. Risks by Strategic Objective:

- Further work has been undertaken to split the risks within strategic objective 1a into the three areas of 1a(i) Patient Safety / 1a(ii) Patient Experience and 1a(iii) Clinically Effective.

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
Feb – 2026	**Cautious** Accept up to 10	25 (66%)	12 (34%)
		37	
		Not able to calculate retrospectively	

Number of risks 15-25	High (15-16)	Very high (20-25)
4	3 (77%)	1 (23%)

- 66% of LCHS risks (25) 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
Feb – 2026	**Cautious** Accept up to 10	148 (62%)	90 (38%)
		238	
		Not able to calculate retrospectively	

Number of risks 15-25	High (15-16)	Very high (20-25)
26	20 (77%)	6 (23%)

- 62% of ULTH risks (148) are within the 'Cautious' risk appetite.
- There are 6 'Very High' risks.

NB: It should be noted that during January 2026, strategic objective 1a was split into 3 component parts (safety, experience and effective) to better enable risk to be understood within each domain. This means retrospective comparison with reported position in January 2026 is not possible. For the April 2026 report, comparison between months will be possible.

Summary of the risks outside of the Risk Appetite:

LCHS: n=12

ID	Title	Rating (current)
402	Medicines Management Trust wide - includes Pharmacy Staffing	12
403	Children SLT Therapy Assessment and Treatment Delays	20
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)
782	In-reach clinician Macmillan	12
789	Prescribing Governance	12
792	Reduction of Phlebotomy appointments breaching the ICB service spec	15
793	Contracted Pharmacy Service - Co-op Agreed KPIs	12
818	Sleaford ICT Quality of Care to patients and staff well-being	12
822	Consultant not recording eye drops given	12

ULTH: n=90

ID	Title	Rating (current)
4623	CQC inspection outcome	12
4624	Patient falls resulting in serious harm	12
4625	Risk of Outbreak of serious infectious disease	12
4626	Risk of pressure ulcers	12
4646	Provision of NIV treatment	16
4700	Children and young people treated in clinical areas external to the Family Health division	12
4724	Therapies & Rehabilitation Medicine service provision	12
4727	Capacity gaps within individual hubs and within Outpatients	12
4741	Fragility of Oncology services	16
4746	Overdue patients on Ophthalmology PBWL	20
4750	Lack of emergency alarm bell system/phones/call system within Theatres	12
4765	Lack of therapies provision for the Head & Neck Cancer service	12
4769	Insufficient staffing and ultrasound equipment within the Vascular Lab at Pilgrim	16

ID	Title	Rating (current)
5289	Lack of Emergency Buzzers on Day Case Ward Pilgrim	12
5306	Inadequate Specialist Microbiologist input for patient care	16
5320	Shortage of ARSAC Practitioner Licence holders	12
5333	Shortage of Adult Acute Dietetic Staffing Across Inpatient Wards	12
5387	Patient safety delays in clinical assessment by experienced practitioner, due to demands on medical teams out of hours	12
5393	Trust failing to provide x-ray imaging referrers (within and outside the Trust) with referral guidelines	12
5414	OAU - Lincoln - do not complete EDD's	12
5429	Risk of service disruption due to Current Cath Labs coming to end of life	12
5433	Insufficient EPAU scan capacity	15
5448	Anaesthetic input for Paediatric Emergency Cases at Grantham UTC	12
5449	ULHT ERCP Service	12
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	20
5491	Risk of Clinical treatments being carried out in rooms that do not have the appropriate ventilation levels.	16

ID	Title	Rating (current)
4770	Ageing medical and diagnostic equipment throughout the Trust is overdue for replacement	12
4779	Delays in Stroke Services	12
4782	Increasing backlog of planned care activity across the Cardiovascular CBU	12
4789	Processing of Echocardiograms	16
4843	Lack of Senior Immunology expertise within Lincolnshire & resulting impact on Patient Safety and ULTH practice	16
4855	Delayed diagnosis of breast cancer and increased waits to treat confirmed cancers	16
4868	Inappropriate preparation of c-section medication	16
4877	Planned care pathway delays	12
4878	Planned care non-admitted pathway (outpatients)	12
4879	Recovery of planned care cancer pathways	20
4891	Following termination of AQP - Ultrasound capacity not meeting demand	12
4928	Delays in Cardiology Outpatient Appointments	12
4952	Branston ward escalation to assist with Gynaecology emergency admissions	12
4955	Processes for the repackaging and over labelling of medicines	12
4975	Non-compliance with all elements of the Paediatric Oncology Shared Care Unit measures	12
4978	Gynaecology cancer metrics	12
4989	Failure to read or act on radiology reports	12
5002	Patient access to specialist palliative care	16
5005	Compliance with GDPR / Data Protection Act in Specialist Palliative Care	12
5016	Patient Flow Through Emergency Departments.	20
5095	PICC Line Service Delays	16
5099	Risk of a delay in haematology and oncology patients receiving specialist review / input	12

ID	Title	Rating (current)
5493	Risk to delivery of Paediatric Dietitian service due to workforce gaps	12
5508	Reputational and Patient Safety Risk due to failure to meet NatPSA/2023/010/MHRA deadline	12
5515	Lack of capacity to meet demand for Elective Caesarean Section	12
5520	Delays to mechanical Thrombectomy for patients presenting with large vessel occlusion/acute stroke	16
5525	Insufficient midwifery staffing for antenatal triage	12
5533	Failure of adherence to NICE Guidelines – risk of life changing disability	16
5536	Funding for AHP Provision for Neonatal Care	12
5538	Reduced senior nursing staff and insufficient skill mix on Ward 4a	12
5542	Risk of Pleural Service	12
5555	Lack of suitable facilities for face-to-face Vascular MDT meetings	12
5557	Lack of Level 1 enhanced care trained staff on Ward 5B	12
5558	Clinical imaging software - lack of availability-Dermatology	12
5610	Inadequate Administration staffing in Haematology	12
5614	Paediatric Audiology Service not meeting the Paediatrics Quality Standards	16
5617	Insufficient maternity triage system	16
5621	Lack of Trustwide orthogeriatric cover	12
5647	Workforce required to safely manage and maintain the e-PMA system for Systemic Anti-Cancer Therapy (SACT) (Varian-Aria)	12
5651	East Midlands Cancer Alliance Centre for Psychosocial Health withdrawal of funding	16
5654	Staffing shortages within Dietetics Oncology Team	12
5658	Poor condition of Ward 1B	12
5663	Insufficient number of Tier 1 and Tier 2 paediatric doctors overnight at Pilgrim	12
5665	Stroke service – delay in receiving abnormal blood test results.	12

ID	Title	Rating (current)
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	20
5146	Termination of pregnancy service currently unable to meet RCOG standards	15
5165	Non-compliance with Local and National policy and NPSA 20 on the safe prescribing of injectable medicines	12
5181	SACT capacity does not meet demand	15
5196	Non-compliance with medicines storage audits	15
5200	Backlog of Paediatric Cardiology clinics	20
5205	Risk of using less reliable and old equipment - Radiotherapy Treatment Equipment	12
5228	Non-Compliance with Cauda Equina Service	12
5256	End of Life notice on our Philips Brightview XCT gamma camera	12
5271	Increasing demand on capacity of children's area of ED	12

ID	Title	Rating (current)
5668	Increased demand within the Pre-diagnosis Team	12
5683	Insufficient maternity triage processes	12
5688	PHB Waiting Room-shared ED and Outpatients waiting room risk.	12
5708	No allocated Occupational Therapy resource for Prehab Cancer provisions	12
5713	Risk of inability to run Cardio-Diabetes service	12
5724	Lack of vitreoretinal consultant to deal with retinal detachment emergencies	12
5731	Insufficient capacity to undertake timely fractured neck of femur surgery	12
5737	Therapy Admin Team Workforce Shortfall Impacting Service Delivery	12
5741	Lack of robotic theatre availability for colorectal cancer surgery	12
5744	Lack of a Patient Supplies Administrative Coordinator	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
403	Children SLT Therapy Treatment Delays	Very high risk (20-25)	Children, Young People, and Specialist Services	Recognising that the initial risk has changed as a result of the new model of working that has successfully mitigated and reduced the risk for pre-school children, the risk will be closed and split into two new risks to represent the residual risk for pre-school children, which is a lower risk now, and the high risk still present for school age and specialist referrals which will be presented at RRC&C in February.	30/01/2026

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	Discussed at Specialty Governance meeting on 13th January - there are currently 5597 patients on the PBWL. The clinical validation process is ongoing with 654 patients reviewed to date, of which 67 patients have been discharged. A non-clinical validation process in progress.	20/01/2026
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Corporate	Recovery trajectory in place to reduce 62+ day breaches to 245 by March 2026, supported by an intensive specialty-level review to identify and mitigate residual risks. Weekly Care Group Intensive Support meetings have been established, with performance trajectories set at Trust and tumour site level for the 28 day FDS, 62 day and 31-day standards, aligned to national expectations and local targets for backlog reduction. Since September 2025 Head of Cancer has been appointed to provide strategic oversight and operational leadership across cancer pathway.	20/01/2026

ID	Title	Risk level (current)	Care Group	Progress update	Date of latest review
5016	Patient Flow Through Emergency Departments.	Very high risk (20-25)	Medicine	A new front door streaming project has begun with the introduction of the Initial Assessment Model across our UEC services at Lincoln County Hospital. The aim of this new model is to address pressures at the front door, reduce impact on ED by reducing inappropriate ED attendances, improve patient experience, and decrease long wait times for assessment and treatment. An acuity score will be used to determine pathways to care.	20/01/2026
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	Very high risk (20-25)	Family Health	The risk remains **Very High** due to several critical and unresolved issues affecting service resilience, patient safety, and operational sustainability: **1. Single Point of Failure at Consultant Level -** Consultant continues to hold sole responsibility for a complex caseload of approximately 600 children—four times the caseload typically managed by regional peers. No alternative consultant is available to provide cover or continuity. Any period of unavailability would leave a large cohort of high-risk patients without specialist oversight. **2. Reliance on Unscheduled and Unpaid Work to Maintain Safety** - Consultant and the Epilepsy specialist nursing team consistently work well beyond their contracted hours in order to prevent service deterioration. The fragility of the service is highlighted by Consultant working 10 days during her most recent two-week period of annual leave to support clinical decision-making. If the team worked strictly to contract, a rapid and severe degradation of service quality and safety is likely. **3. Limited Insight from Epilepsy12 Audit Data -** Although results from the Epilepsy12 audit appear favourable, the dataset is restricted to newly diagnosed children and therefore provides no visibility of performance in managing the far larger cohort of complex, long-standing patients. Prioritisation of newly diagnosed patients—driven by limited resource—creates a misleading picture of assurance and diverts attention from those with the highest clinical risk. **4. Incomplete Understanding of the True Epilepsy Caseload -** The service does not hold an accurate record of the total epilepsy population. A number of children with epilepsy remain under the care of non-specialist consultants because Consultant is at full capacity, those hildren receive no epilepsy nurse specialist input, creating a significant likelihood of unrecognised issues and raising concerns about the safety and adequacy of their care. **5. Recent Serious Events -** Since October 2023, the Trust has experienced three SUDEP cases and two further deaths involving children with epilepsy that were later categorised as SUDIC. These events highlight the increased vulnerability of the patient group and the urgent need for strengthened oversight and capacity. **6. Escalating Demand and Complexity in Nursing Caseload -** The nursing caseload currently stands at approximately 160 children, but this does not capture the substantial volume of families who regularly seek advice and support outside of scheduled reviews. The complexity of cases continues to rise, placing further strain on limited workforce capacity. **7. Increased Likelihood of Uncontrolled Seizures and Adverse Outcomes -** Due to insufficient oversight and depleted capacity across the team, many children are at heightened risk of poorly controlled seizures. Uncontrolled seizures can lead to irreversible harm or sudden death, and this remains an ongoing and material patient safety concern.	13/01/2026
5200	Backlog of Paediatric Cardiology clinics	Very high risk (20-25)	Family Health	Risk to be closed as the backlog of patients has been cleared and all patients have now been seen as required following the appointment of a consultant on a fixed term basis. Ongoing risk remains in relation to the single point of failure in this service provision – new risk to be raised, to be presented at Cabinet for agreement in December and RRC&C in January.	13/01/2026
5450	Risk of Gastro service not being viable due to current fragility of Consultant workforce	Very high risk (20-25)	Medicine	Work not started for moving Gastro service into community. Risk remains unchanged for now pending further recruitment as still dependent on agency - If current round of recruitment successful pending further partial retirement approved by ROAG then to explore if risk to be downgraded.	19/01/2026

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
Feb – 2026	**Open** Accept up to 12	8 (100%)	0 (0%)
		8	
		Not able to calculate retrospectively	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)

- 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
Feb – 2026	**Open** Accept up to 12	31 (86%)	5 (14%)
		36	
		Not able to calculate retrospectively	

Number of risks 15-25	High (15-16)	Very high (20-25)
4	3 (75%)	1 (25%)

- 86% of ULTH risks (31) are within the 'Open' risk appetite.
- There is 1 'Very High' risk.

NB: It should be noted that during January 2026, strategic objective 1a was split into 3 component parts (safety, experience and effective) to better enable risk to be understood within each domain. This means retrospective comparison with reported position in January 2026 is not possible. For the April 2026 report, comparison between months will be possible.

Summary of the risks outside of the Risk Appetite (n=5):

ULTH

ID	Title	Rating (current)
4731	Reliance on paper medical records	20
5003	Workforce deficit for Specialist Palliative Care	16
5004	Palliative and End of life care Organisational risk	12
5216	Radiotherapy Staffing levels	16
5495	Lack of adequate provision for appropriate care of bereaved families with 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.	16/01/2026

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
Feb – 2026	**Open** Accept up to 12	7 (100%)	0 (0%)
		7	
		Not able to calculate retrospectively	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- 100% of LCHS risks (7) 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
Feb – 2026	**Open** Accept up to 12	15 (100%)	0 (0%)
		15	
		Not able to calculate retrospectively	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- 100% of ULTH risks (15) are within the 'Open' risk appetite.
- There are no 'Very High' risks.

There are no risks outside of the Risk Appetite.

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
Feb – 2026	**Open/ Cautious** Accept up to 12	4 (80%)	1 (20%)
		5	
Dec – 2025		6 (86%)	1 (14%)
		7	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	1 (100%)	0 (0%)
1	1 (100%)	0 (0%)

- 80% of LCHS risks (4) are within the 'Open/Cautious' risk appetite There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risk.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Feb – 2026	**Open/ Cautious** Accept up to 12	13 (76%)	4 (24%)
		17	
Dec – 2025		14 (82%)	3 (18%)
		17	

Number of risks 15-25	High (15-16)	Very high (20-25)
4	4 (100%)	0 (0%)
3	2 (67%)	1 (33%)

- 76% of ULTH risks (13) are within the 'Open/Cautious' risk appetite.
- There are zero 'Very High' ULTH risks.
- There are 4 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=5):

LCHS:

ID	Title	Rating (current)
773	Speech and Language Therapy – Capacity and Demand	16

ULTH:

ID	Title	Rating (current)
5267	Delay in processing cardiac MRIs	16
5381	Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands	15
5447	Cancellation of elective lists due to lack of theatre staff	20
5715	Reduction in staffing levels within CT, Ultrasound and MRI Administration Teams (15) following Risk Confirm & Challenge in January risk was validated for **increase in score from 4x3:12 Moderate Risk to 5x3:15** – due to increasing numbers waiting to be booked which is eing affected by significant administration staff vacancy.	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
Feb – 2026	**Open** Accept risks up to12	13 (93%)	1 (7%)
		14	
Dec – 2025		10 (91%)	1 (9%)
		11	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	1 (100%)	0 (0%)
1	1 (100%)	0 (0%)

- 93% of LCHS risks (13) are within the 'Open' risk appetite
- There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Feb – 2026	**Open** Accept risks up to12	67 (93%)	5 (7%)
		72	
Dec – 2025		66 (90%)	7 (10%)
		73	

Number of risks 15-25	High (15-16)	Very high (20-25)
5	2 (29%)	3 (71%)
7	2 (29%)	5 (71%)

- 93% of ULTH risks (67) are within the 'Open' risk appetite
- There are 3 'Very High' ULTH risks.
- There are 2 '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

Following Risk Confirm & Challenge in December, the following risk was validated for **decrease in score**:

- 4657 - Compliance with Subject Access Requests **reduction in score from 5x4:20 Very High Risk to 3x4:16 Moderate Risk –** due to position is much improved in the service and performance greatly improved, with fewer complaints to the Trust and ICO.

Following Risk Confirm & Challenge in January 2026, the following **Very High Risk** was agreed **for closure**:

- ULTH: 4839 – Lack of pharmacy capacity for Intravenous Immunoglobulin (IVIG) (20) – all staff now in post and fully compliant with relevant training requirements.

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.	20/01/2026
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	20/01/2026
ULTH	5672	Risk of failure to deliver the CIP target in full for 2025/2026	Very high risk (20)	Corporate	Increased CIP governance & monitoring arrangements introduced through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups). Business cases submitted to NHSE for Delivery support in key areas where capacity & expertise require. Development of future programme of cost improvement. Additional resource supported in Financial Improvement. Further pipeline opportunities being developed. Discussions with system partners and regional colleagues on specific issues. Further deterioration of CIP position at month 7. Medical workforce programme reinstated under CMO with targets set for each Care Group.	20/01/2026

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)
Feb - 2026	**OPEN** Accept up to 12	14 (88%)	2 (12%)	2	2 (100%)	0 (0%)
		16				
Dec - 2025		14 (88%)	2 (12%)	2	2 (100%)	0 (0%)
		16				

- 88% of LCHS risks (14) are within the 'Open' risk appetite
- There are zero 'Very High' LCHS risks.
- There are 2 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb - 2026	**OPEN** Accept up to 12	91 (88%)	12 (12%)	12	12 (100%)	0 (0%)
		103				
Dec - 2025		90 (88%)	12 (12%)	12	12 (100%)	0 (0%)
		102				

- 88% of ULTH risks (91) are within the 'Open' risk appetite
- There are zero 'Very High' ULTH risks.
- There are 12 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=14):

LCHS:

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

ID	Title	Rating (current)
5334	Lack of second theatre available to use on Pilgrim Labour Ward	16
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

Following Risk Confirm & Challenge in January 2026, the following **High Risk** was agreed **for closure**:

- ULTH: 4858 – Critical failure of the water supply, Trust wide (15) – risk closed as duplicate of Risk 5579 Water and Heating System Pipe work and Infrastructure (9)

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	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb - 2026	**OPEN** Accept up to 12	6 (75%)	2 (25%)	2	2 (100%)	0 (0%)
		8				
Dec – 2025		9 (100%)	0 (0%)	2	2 (100%)	0 (0%)
		9				

- 75% of LCHS risks are within the 'Open' risk appetite.
- There are zero 'Very High' LCHS risks.
- There are 2 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb - 2026	**Open** Accept up to 12	14 (65%)	10 (35%)	10	9 (90%)	1 (10%)
		24				
Dec – 2025		13 (62%)	8 (38%)	8	7 (87%)	1 (13%)
		21				

- 65% of ULTH risks (14) are within the 'Open' risk appetite.
- There is 1 'Very High' risk.
- There are 9 'High' risks.

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[3]	Moving and Handling – poor compliance	16

ULTH:

ID	Title	Rating (current)
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
5468	Failure to meet contractual requirements in Pharmacy teaching	16
5691	Reduction of staffing levels within the PACS Team	16

[3] **Reporting Exception:** Risk ID 715 and ID 754 were omitted from the previous report due to an administrative error. Both risks were outside the organisation's risk appetite at the time of omission, the risks are now included in this report.

Following an action directed by the Integration Committee, a further review of risk alignment has been undertaken by the Deputy Chief Clinical Governance Officer and the Group People Officer and the following risks have been realigned to the People Committee:

ID	Title	Rating (current)
4780	Significant deficit in Stroke consultant staffing	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

Following Risk Confirm & Challenge in December 2025, the following **High Risk** was agreed **for closure**:

- ULTH: 5154 - Medicines Management training not available on ESR (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:** 19/01/2026

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)
Feb – 2026	**Hungry** Accept risks of 15/16	4 (100%)	0 (0%)	1	1 (100%)	0 (0%)
		4				
Dec – 2025		5 (100%)	0 (0%)	1	1 (100%)	0 (0%)
		5				

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risk.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb – 2026	**Hungry** Accept risks of 15/16	12 (80%)	3 (20%)	5	2 (40%)	3 (60%)
		15				
Dec – 2025		13 (81%)	3 (19%)	5	2 (40%)	3 (60%)
		16				

- 80% of ULTH risks (12) are within the 'Hungry' risk appetite.
- There are 3 'Very High' ULTH risks.
- There are 2 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=3):

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

Summary of the 'Very High' risks (n=3):
ULTH:

Trust:	Risk ID	What is the risk?	Risk rating	Risk reduction plan	Date added to register and latest review:
ULTH	4844	As a result of insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy dispensing service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only. The dispensary workloads exceed the staffing capacity. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed, there is a risk that pharmacy staff working long hours without a break could make errors, pharmacy staff could become unwell due to working conditions, patients could be discharged from hospital without vital medication and pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, long term effects on pharmacy staff health and wellbeing and the pharmacy departments ability to retain staff.	Very high risk (20)	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.	**Date added to the Trust Register:** 19/01/2022 **Date of latest review:** 15/01/2026
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)	Risk remains the same as further investment still required. This situation will further decline in December when 2 Consultants leave the Boston site. Currently recruiting to these posts.	**Date added to the Trust Register:** 22/08/2022 **Date of latest review:** 19/01/2026
ULTH:	5093	As a result of vacancies and long term absence within the invoicing team, purchasing and pharmacy stores team there is a risk that any further absence or leavers will mean the remaining staff don't have the capacity to do the work of all 3 sites which would impact staff wellbeing and all drug ordering across all pharmacy sites (including bulk IV fluids, medical gases, chemotherapy). Inability to complete invoices will negatively impact the Trust finance target to pay invoices within 30 days, with potential of financial penalties, and could result in suppliers putting holds on our accounts rendering us unable to order medicines, this will therefore mean that we would be unable to complete biosimilar switches and meet CIP targets (£1.4m). Payment beyond 30 days presents a risk of companies levying late payment fees and interest on outstanding amounts.	Very high risk (20)	Storekeeper has started in post. 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. Potential to reduce the risk score to be discussed at next Pharmacy Governance meeting.	**Date added to the Trust Register:** 16/02/2023 **Date of latest review:** 20/01/2026

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
Feb – 2026	**OPEN** Accept up to 12	1 (100%)	0 (0%)
		1	
Dec – 2025		1 (100%)	0 (0%)
		1	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Feb – 2026	**OPEN** Accept up to 12	8 (100%)	0 (0%)
		8	
Dec – 2025		8 (100%)	0 (0%)
		8	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.
- There are zero 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=0):

- There are none.

Summary of the 'Very High' risks (n=0):

- There are none.

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)
Feb – 2026	**Hungry** Accept risks of 15/16	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Dec – 2025		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb – 2026	**Hungry** Accept risks of 15/16	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				
Dec – 2025		1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.
- There are zero 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=0):

- There are none.

Summary of the 'Very High' risks (n=0):

- There are none.

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)
Feb – 2026	**OPEN** Accept up to 12	4 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		4				
Dec – 2025		5 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		5				

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb – 2026	**Open** Accept up to 12	10 (59%)	7 (41%)	7	5 (71%)	2 (29%)
		17				
Dec – 2025		10 (50%)	10 (50%)	10	8 (80%)	2 (20%)
		20				

- 59% of ULTH risks (10) are within the 'Open' risk appetite.
- There are 2 'Very High' ULTH risks.
- There are 5 '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

Following an action directed by the Integration Committee, a further review of risk alignment has been undertaken by the Deputy Chief Clinical Governance Officer and Group People Officer. The following risks have been realigned to the People Committee:

ID	Title	Rating (current)
4780	Significant deficit in Stroke Consultant staffing	16

ID	Title	Rating (current)
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

Summary of the 'Very High' risks (n=2):
ULTH:

Trust:	Risk ID	Risk Title	Risk score	Division	Progress Update	Date of latest review:
ULTH	5563	Neurology – Service sustainability	Very high risk (20)	Medicine	Neurology moving to Alliance Care Group represents significant further risk given current lack of sustainability in model/size of specialty and uncertainty re: management for the future. ICB cluster/changes and current financial landscape means meaningful discussions cannot progress. Service to attend Quality Committee in February for discussion. 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 awaiting extension into January.	**Date of latest review:** 04/02/2026
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.	03/02/2026

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)
Feb – 2026	**Hungry** Accept risks up to15/16	4 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		4				
Dec – 2025		6 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		6				

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb – 2026	**Hungry** Accept risks up to 15/16	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Dec – 2025		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- There are zero ULTH risks aligned to this objective.

Summary of the risks outside of the Risk Appetite (n=0):

- There are none.

Summary of the 'Very High' risks (n=0):

- There are none.

4.13: 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)
Feb – 2026	**HUNGRY** Accept up to 15/16	11 (100%)	0 (0%)	1	1 (10%)	0 (0%)
		11				
Dec – 2025		10 (100%)	0 (0%)	1	1 (10%)	0 (0%)
		10				

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There is 1 'High' LCHS risk.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Feb – 2026	**HUNGRY** Accept up to 15/16	77 (100%)	0 (0%)	4	4 (5%)	0 (0%)
		77				
Dec – 2025		79 (100%)	0 (0%)	4	4 (5%)	0 (0%)
		79				

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.
- There are 4 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=0):

- There are none.

Summary of the 'Very High' risks (n=0):

- There are none.

4.14: 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
Feb – 2026	**OPEN** Accept up to 12	3 (100%)	0 (0%)
		3	
Dec – 2025		3 (100%)	0 (0%)
		3	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- All LCHS risks are within the risk appetite established.
- There are zero 'Very High' LCHS risks.
- There are zero 'High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Feb – 2026	**OPEN** Accept up to 12	2 (100%)	0 (0%)
		2	
Dec – 2025		2 (100%)	0 (0%)
		2	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- All ULTH risks are within the risk appetite established.
- There are zero 'Very High' ULTH risks.
- There are zero 'High' ULTH risks.

Summary of the risks outside of the Risk Appetite (n=0):

- There are none.

Summary of the 'Very High' risks (n=0):

- There are none.

Appendices

- Appendix A – LCHS Quality Committee Very High and High Risks Mar 2026.
- Appendix B – ULTH Quality Committee Very High and High Risks Mar 2026.
- Appendix C – Further detail of the risk appetite agreed by the Group.
- Appendix D – Full list of risks outside of Risk Appetite by Strategic Objective.

ID	403
Risk Type	Physical or Psychological Harm
Executive Lead	Group Chief Operating Officer
Risk lead	Keeling, Kerry-Jane
Committee Responsible	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)
Opened	13/09/2022
Rating (initial)	9
Division	Children, Young People, and Specialist Services
Service	Children's Therapy
Risk Description	As a result of an increase in demand nationally & regionally for SLT support there is a risk that children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in an appropriate timeframe for their development, resulting in poor cognitive & social outcomes increasing lifelong health inequalities.
Controls in Place	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
Date of latest risk review	30/01/2026
Likelihood (current)	Extremely likely (5) >90% chance
Severity (currently)	Severe (4)
Risk level (current)	Very High Risk (20-25)
Rating (current)	20
Progress update	[02/02/2026 13:23:25 Sarah Davy] Recognising that the initial risk has changed as a result of the new model of working that has successfully mitigating and reduced the risk for pre-school children, the risk on the Trust's risk register will be split into two to represent the residual risk for pre-school children, which is a lower risk now, and the high risk still present for school age and specialist referrals. [06/01/2026 14:47:04 Daniel Thompson] Marginal improvements in 18 week breaches with longest wait slightly reduced to 41 weeks. Longest wait for review is 45 weeks. Improvements in access for pre-schoolers with pilot. However, risk to school aged remains very high with up to 65 week wait for therapy. Service continues to use restricted criteria to access service meaning there is a continued unmet need for this population. Received 6x complaints in November relating to
Risk level (acceptable)	Low Risk (4-6)
Review date	05/02/2026
Movement on risk	No change

Quality Committee

Strategic Objective: 1a (i) Improve patient safety

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
681	Regulatory Compliance	Group Chief Operating Officer	Keeling, Kerry-Jane	Quality Committee (Lead assurance committee), Risk Register Confirm & Challenge (Accountable for), Patient Safety Group (Accountable for)	05/02/2024	20	Planned Care Group		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.	06/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[06/01/2026 14:48:54 Daniel Thompson] Interviews for doctor scheduled later in January. No other changes to service. Risk remains as is. [02/10/2025 15:07:06 Ana Morgan] Risk reviewed at CYPSS Quality SMT 02/10/2025: post out for recruitment for the second time as fixed term; applicants are being shortlisted. Risk score remains high. [17/09/2025 11:51:12 Sarah Davy] Reviewed at RRC&C on 17 Sept agreed to increase in score from 3x4=12 to 4x4=16 High Risk. [05/09/2025 14:02:41 Ana Morgan] Risk reviewed by DDL and CSL: The doctor provided by ULTH on an SLA basis joined the service in February and left July, working only part of that month. The service's bank capacity is variable as it's reliant on the availability of one particular clinician, who has been absent throughout most of the summer period and will continue to be so in September. ULTH are currently out to advert to recruit a permanent	Very Low Risk (1-3)	02/04/2026	No change

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
714	Physical or Psychological Harm	Group Chief Operating Officer	Wills, Zoe	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	16/05/2024	16	Collaborative Community Care		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	02/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[02/12/2025 16:15:09 Sarah Davy] Bespoke meeting regarding increase in Section 42s on 28/11 agreed focus on BSafe meetings. CSLs and Safeguarding to attend. Work ongoing by AW on benchmarking data. [11/11/2025 15:44:09 Zoe Wills] 11/11/2025 - We have seen a significant increase in S42s in October. We are reviewing these and triangulating whether there has been a delay in reporting and themes that have been identified. There are still issues with equipment provision and this links to 772. [05/08/2025 15:20:40 Zoe Wills] 05/08/2025 - Due to challenges of equipment ordering this risk continues to be high. Ongoing work in Community Teams on PU management. Re established and focused monthly meeting for sharing learning across teams and to keep track of improvement actions. [06/05/2025 15:16:18 Zoe Wills] 06/05/2025 - Update going through to Patient Safety Group, still seeing	Moderate Risk (8-12)	02/03/2026	No change

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
742	Regulatory Compliance	Group Chief Nurse	Wills, Zoe	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	02/08/2024	15	Collaborative Community Care	4 Counties ICT	As a result of lack of professional chaperones due to lone working and capacity constraints, there is a risk that community nurses cannot provide a chaperone during intimate examinations, leaving patients and staff unsafeguarded against actual or perceived abuse, resulting in risk to patient safety and risk to staff.	Service to initiate a Double up system if deemed to be required following triage of vulnerable patients referred for care Utilisation of care home staff where appropriate At present there has no incidence of actual or perceived abuse being reported following intimate examinations at LCHS	11/11/2025	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	[11/11/2025 15:56:06 Zoe Wills] 11/11/2025 - We have looked through complaints and incidents and we are not seeing anything relating to this risk. This could be because we are not asking the question when completing procedure. ZW meeting with Kat Shaw to discuss 11/11/2025. [02/09/2025 16:04:41 Angela Wilson] To be discussed with Clinical Director. No Datix submitted [03/06/2025 15:26:49 Zoe Wills] 03/06/2025 - No update still awaiting information from senior leadership team. [04/03/2025 15:38:05 Zoe Wills] 04/03/2025 - Discussed at risk meeting - still on hold. No incidents recorded over the past 3 month. Awaiting confirmation from chief nurse. [08/11/2024 21:23:37 Ana Morgan] [05/11/2024 15:09:53 Zoe Wills] 05/11/2024 - Group Chief Nurse to discuss with safeguarding lead around amendment of the policy. MB to chase. Currently on HOLD	Low Risk (4-6)	10/02/2026	NEW RISK

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
792	Physical or Psychological Harm		Perry, Collette	Quality Committee (Lead assurance committee), Patient Safety Group (Accountable for)	13/05/2025	15	Collaborative Community Care – Community Hospitals	Outpatients Department, Johnson Hospital	As a result of unrectified staffing and clinic establishment issues within the budget, leading to inability to recruit replacement staff, there is a risk that phlebotomy services will experience reduced availability, resulting in delays for routine blood appointments (currently 16-day wait), late diagnostic tests, treatment delays, increased patient safety concerns, added workload and stress for remaining staff, potential staff absence, and reputational damage to the service.	Highlighted risk to CSL- Discussion at QSG Add to risk register	14/01/2026	Extremely likely (5) >90% chance	Moderate (3)	High Risk (15-16)	15	[14/01/2026 12:34:52 Liana Arnold] Activity is back within expected levels. To be discussed at QSG next week for closure. [16/10/2025 15:13:50 Sarah Davy] Email from Zoe Wills on 14/10 requesting risk to remain open following recent developments - specifically refusal of vacancy at control panel, situation to be reviewed further before decision made to close risk. [08/10/2025 12:44:42 Zoe Wills] 08/10/2025 - Clinic has increased capacity and staff in post and trained. This has resulted in waiting list down to routine - 1 day. and urgent - 0 days [11/07/2025 17:19:24 Lisa Jennings] Update from Divisional risk meeting provided by CSL EG: Recruitment of x2 HCSWs approved. Recruitment process in progress. New recruits to be in post by end of August 2025. Bank staff covering gaps at present. Waiting time for both routine and emergency phlebotomy appointments much improved.	Very Low Risk (1-3)	13/02/2026	No change
Finance & Performance Committee																			
Strategic Objective						**1b: Reduce waiting times for our patients**													

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
773			Evans, Amy	Finance Committee (Lead assurance committee)	13/01/2025	16	Planned Care Group		As a result of gaps in staffing, limited non-registered support, and training requirements for newly qualified staff, there is a risk that LCHS will fail to meet urgent speech and language needs for adults in Lincolnshire, resulting in delays to dysphagia and communication assessments, increased risk of aspiration and hospital admissions, reduced quality of life, breaches of statutory waiting times, and negative impact on staff morale and retention.	Clinical prioritisation - dysphagia as the priority due to severe impact of delays. Changes to waiting list management - delay offer / opt in for any communication assessments as unable to provide the therapy intervention / assessment. Prioritise training for new starters in Dysphagia and Voice assessments to manage these caseloads. Provision of care home pack for all referrals. Conversion to video consultations / reviews where possible. Support from partners in the acute 1 day / week with dysphagia & high priority communication assessments.	06/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[06/01/2026 15:00:29 Daniel Thompson] Longest wait 33 weeks (x2). Rest are 21 and below. 9 breaches over 18 weeks. 188 waiting for assessment. Additional processes in place for flow management, discharges, offering of virtual clinics, adaptations to managing patients including advice/ self-help. Reduced caseload by 42. Balance of acute workforce sickness which has limited improvement. [08/10/2025 15:24:16 Amy Evans] Additional information to support review at CYPSS Quality SMT 2/10/25 - actions to be implemented to reduce further escalation and recovery waiting lists / long waits for therapy to include: Review / update referral form, return referrals where not appropriate / outstanding actions for referrer to be completed, consider screening assessments to support prioritisation, increased provision of self management advice and guidance for P4 priority, increase telephone triage from B7 capacity, reduce planned review for	Low Risk (4-6)	02/04/2026	Decrease in score
Strategic Objective									**1c: Improve productivity and deliver financial sustainability**										

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
805	Finances	Group Chief Finance Officer	Taylor, James	Finance Committee (Lead assurance committee)	08/08/2025	20	Corporate	Finance	As a result of lack of identified efficiency plans; non-delivery of identified schemes; delays in implementing efficiency savings of increased complexity due to system implications there is a risk that the Trust will fail to deliver the efficiency requirement aspect of the financial plan, resulting in reputational damage including reduction in the SOF rating and/or lack of financial sustainability going forward, and a failure to meet statutory financial duties.	1. Financial plan and budgets approved and delegated. 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.	27/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[27/01/2026 14:49:02 Sarah Davy] To be presented at February RRCC for reduction in score to 2x4=8. [27/01/2026 14:40:02 James Taylor] Reduction in risk to target level of 8. CIP delivery fully underpinned and over delivery vs Plan of £1.1m as at Month 9. Next review scheduled for End April - to review, close and replace with 26/27 CIP risk [20/08/2025 11:49:42 Rachael Turner] New risk presented at RRC&C meeting 20/08/25. Currently 3.7 million to be underpinned. Finance will continue to review and monitor progress around this. Risk validated at 4x4:16 High Risk.	Moderate Risk (8-12)	24/04/2026	NEW RISK
Strategic Objective									**1d: Provide modern, clean and fit for purpose care settings**										

ID	799
Risk Type	Regulatory Compliance
Executive Lead	Group Chief Estates & Facilities
Risk lead	Davey, Keiron
Committee Responsible	Finance Committee (Lead assurance committee), Fire Safety Group (Accountable for)
Opened	04/07/2025
Rating (initial)	25
Division	Corporate
Service	Estates
Risk Description	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.
Controls in Place	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
Date of latest risk review	03/11/2025
Likelihood (current)	Quite likely (4) 71-90% chance
Severity (currently)	Severe (4)
Risk level (current)	High Risk (15-16)
Rating (current)	16
Progress update	[03/11/2025 13:01:19 Rachael Turner] New Fire Policy is now complete and available Group Wide. There is training aligned across the Group. LCHS is now integrated into FEG & FSG for compliance, governance and assurance on fire safety management. [20/08/2025 11:51:57 Rachael Turner] Risk presented at RRC&C meeting 20/08/25. Risk validated at 4x4:16 High Risk. [06/08/2025 14:21:20 Ana Morgan] For review at Fire Safety Group 06/08/25 New Risk to encompass the results if a major fire occurred
Risk level (acceptable)	Moderate Risk (8-12)
Review date	03/02/2026
Movement on risk	NEW RISK

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
649	Regulatory Compliance	Group Chief Estates & Facilities	Thomas, Simon	Finance Committee (Lead assurance committee), Health and Safety Committee (Accountable for), Fire Safety Group (Accountable for)	12/09/2023	15	Corporate	Estates	As a result of inadequate fire protection measures, maintenance, training, and policies, there is a risk that the Trust cannot demonstrate statutory compliance with the Regulatory Reform (Fire Safety) Order 2005, resulting in potential regulatory action, financial penalties, service disruption including possible site closures, loss of facilities, and risk of injury to patients and staff.	1. LCHS Fire Safety Operational Meeting 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	19/11/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High Risk (15-16)	15	[19/11/2025 12:35:13 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Register Confirm and Challenge 19/11/2025. Risk to be reviewed and then returned for possible reduction in score. [03/11/2025 12:59:55 Rachael Turner] New Fire Policy is now complete and available Group Wide. There is training aligned across the Group. LCHS is now integrated into FEG & FSG for compliance, governance and assurance on fire safety management. [04/07/2025 11:32:13 Keiron Davey] reviewed description of risk to include sanctions by Fire Safety Regulators and consequences. additional control measures also included to include policy protocols, and over sight by FEG, FSG and HS Committee etc [14/04/2025 09:16:44 Russell Fordham] No change to the score or risks in this period and monthly and quarterly fire operational meetings are being attended by NHSPS to try to resolve the actions identified in	Low Risk (4-6)	03/02/2026	No change
People Committee																			
Strategic Objective						**2a: Enable our people to fulfil their potential through training, development and education**													

ID	754
Risk Type	Physical or Psychological Harm
Executive Lead	Group Chief Estates & Facilities
Risk lead	Kidger, Leanne
Committee Responsible	People Committee (Lead assurance committee), Health and Safety Committee (Accountable for)
Opened	09/10/2024
Rating (initial)	15
Division	Corporate
Service	Quality
Risk Description	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.
Controls in Place	Mutual support request to ULHT. Internal sources of alternate training support being identified. Reviewing training schedule and package. Action plan in place to increase attendance when training is reinstated. Engagement with operational colleagues to confirm appropriate staff requiring training. Training for new staff continues.
Date of latest risk review	15/10/2025
Likelihood (current)	Quite likely (4) 71-90% chance
Severity (currently)	Severe (4)
Risk level (current)	High Risk (15-16)
Rating (current)	16
Progress update	[15/10/2025 11:44:48 Ana Morgan] Risk reviewed with Moving and Handling Clinical Lead LK & EP Lead 15/10/25: training has been reviewed by M&H expert and appropriate training packages for each area have been developed. Delivery has commenced following a short pause, and compliance is increasing. To monitor if compliance continues to improve (currently 64.67%) and consider score reduction at next review date. [10/04/2025 13:36:35 Russell Fordham] Training is going to be run through a group model and meetings between all trainers and providers are working together. [13/02/2025 12:45:14 Russell Fordham] 18/12/2024. RF Meetings between LCHS and ULHT manual hander ling teams have been conducted, Peer review and cross party working is being implemented to embed one process and support compliance and improvements needed. Good progress being made and site
Risk level (acceptable)	Very Low Risk (1-3)
Review date	05/01/2026
Movement on risk	No change

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
715	Physical or Psychological Harm	Group Chief People Officer		People Committee (Lead assurance committee)	16/05/2024	16	Collaborative Community Care		As a result of increased service demand, and reduced numbers of DNSPQ-qualified staff, there is a risk that the community nursing service will be unable to meet patient demand in Lincolnshire, resulting in variance in care delivery, ineffective caseload management, poor patient experience, reduced efficiency for complex cases, and task-based care with limited holistic planning.	Daily BSafe - escalation/oversight review Twice daily matron led safety huddles Re allocation of senior resource to at risk areas Operational oversight of risk daily Service evaluation of DNSPQ role Support from UCR and CYPSS services to aid meeting unplanned demand when required	02/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[02/12/2025 15:46:34 Sarah Davy] Work ongoing on Community Nursing workforce transformation. Teams still seeing high unavailability as sickness rates average 7.5% in October. 11 WTE NQ joining service in January 2026 across all teams. [02/09/2025 16:06:17 Angela Wilson] No change [03/06/2025 15:30:00 Zoe Wills] 03/06/2025 - Holding vacancies for apprenticeships has meant high unavailability in all teams. This has caused reduced capacity. Work ongoing to move VBYV into teams helping support unavailability. [04/03/2025 15:47:25 Zoe Wills] 04/03/2025 - We are currently seeing high unavailability in Sleaford, Skegness and Four Counties. Maternity and sickness rates have gone up impacting on this. Community Nursing Teams are unable to back fill people going of on maternity. [05/11/2024 15:21:59 Zoe Wills] 05/11/2024 - No change currently [08/10/2024 15:09:13 Zoe Wills]	Low Risk (4-6)	02/03/2026	No change
Strategic Objective									**2b: Empower our people to continuously improve and innovate**										

ID	Risk Type	Executive Lead	Risk lead	Committee Responsible	Opened	Rating (initial)	Division	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
695	Service Disruption	Group Chief People Officer	Wills, Zoe	People Committee (Lead assurance committee)	12/03/2024	16	Collaborative Community Care		Due to lack of value placed on the DNSPQ qualification, insufficient training, failure to reimburse and retain staff, and inconsistent use of the Enhanced Practitioner role, there is a risk of reduced numbers of DNSPQ-qualified staff in community nursing teams. This may lead to poor oversight of complex cases, unsafe caseload management, increased risk of patient harm, and inadequate professional support for team development.	BSAFE initiated for daily oversight of safe care BSAFE audits by CSL level staff Reallocation of qualified DNSPQ staff to teams with low levels to aid safety Identification of new assessors for DNSPQ trainees Allocation of trainers to training places for increased trajectory of DNSPQ training Recovery trajectory and commitment to model of care for excellence to be submitted to ELT as part of a wider strategy for service	02/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[02/12/2025 15:56:52 Sarah Davy] New DNSPQ students started course in September - now only 1 team no DN qualified staff member. [02/09/2025 15:42:04 Angela Wilson] No change to current position. [03/06/2025 15:14:21 Zoe Wills] 03/06/2025 - Review required to look at all teams and identify specific areas that are still not meeting the QNI standard requirements. [04/03/2025 15:19:06 Zoe Wills] 04/03/2025 - Risk still scoring 16. We are working towards supporting DNSPQ students. There is a risk that with the qualifications new students are gaining we will be unable to retain staff. [05/11/2024 15:25:19 Zoe Wills] 05/11/2024 - Increasing DNSPQ mentors and 6 people currently going through this process. [08/10/2024 15:19:26 Zoe Wills] 08/10/2024 - Update in 715 as these are linked. [10/09/2024 15:16:33 Zoe Wills] Still awaiting ELT conversation on	Low Risk (4-6)	02/03/2026	No change
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	Service	Risk Description	Controls in Place	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Progress update	Risk level (acceptable)	Review date	Movement on risk
815		Group Chief Integration Officer	Scott, Ian	Integration Committee (Lead assurance committee)	14/10/2025	20	Corporate	Digital Health	As a result of a lack of an established (Digital) Clinical Risk Management System, processes, and resource provision, there is a risk that the Digital Clinical Safety Standards DCB0129 and DCB0160 mandated by NHSE are not met and digital systems are not implemented safely resulting in the risk of harm to patients.	In line with LCHG Group Digital: •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 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	29/01/2025	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	[29/01/2026 17:20:29 Ian Scott] CRMS has been approved by Digital Oversight Group. Digital Services staff consultation completed December 2025 which will support clinical safety alignment and plan in place to link CCDIO (LCHS) into Digital Clinical team (ULTH) and Clinical Safety policy & process over coming months. Some additional temporary ULTH EPR CSO capacity brought in due to over-stretched existing capacity, however this remains inadequate resource to meet demand for ULTH systems. DCSO has begun scoping existing LCHS system need for Clinical Safety assessment and will work with Digital Health team to understand existing and new project work. Digital health staff signposted to Clinical Safety e-learning for awareness and CCDIO to provide overview training session to support this – date TBC. [15/10/2025 10:09:44 Sarah Davy]	Moderate Risk (8-12)	29/04/2026	NEW RISK

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
Quality Committee																										
Strategic Objective								**1a (i) Improve patient safety**																		
5200	283	Physical or psychological harm	Caroline Landon	Coghill, Piper	Shuck, Joanne	Children & Young Persons Oversight Group	30/06/2023	8	Family Health	Children and Young Persons CBU	Paediatric Cardiology		As a result of the Paediatric Cardiology service being covered by a single non substantive Paediatric Cardiologist, there is a risk that a backlog Paediatric Cardiology clinic appointments will recur and patients may not receive diagnosis, follow up, or treatment within appropriate timeframes. This would lead to patient harm, including life limiting outcomes or death.	-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	13/01/2026	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.	[13/01/2026 11:44:02 Nicola Cornish] Business case is currently awaiting seals of approval before submission to CRIG. [15/12/2025 12:37:55 Nicola Cornish] Risk to remain at current grading, despite improvement in waiting list due to provision of additional clinics, in order to support business case. [13/11/2025 10:57:13 Nicola Cornish] This will be discussed at Cabinet meeting in November to agree a reduction in score, before presenting to RRC&C in December for approval. Whilst the backlog has decreased and a cardiology consultant is in post, a risk still remains as this represents a single point of failure and the consultant post is only fixed term for a year. [09/10/2025 09:53:58 Nicola Cornish] Awaiting agreement of cabinet for decrease in risk score to reflect the significant reduction in backlog. Once agreed, this will be listed for RRC&C meeting to confirm approval of the score decrease. [22/09/2025 09:39:09 Nicola Cornish]	8	30/06/2024	30/06/2025	13/02/2026

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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;	13/01/2026	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.	[13/01/2026 12:03:01 Nicola Cornish] There are a number of factors that mean the risk remains Very High: Consultant DH remains a single point of failure - if she becomes unavailable to the service there are no other consultants that can take over her caseload which currently numbers around 600 complex patients (this is significantly greater than the 150 children on the caseload of her regional peers and most likely exceeds the complex caseloads of any of her colleagues); DH and the epilepsy specialist nurses consistently work over and above to keep children safe - if they opted to work to rule, we would most likely see a rapid and catastrophic collapse of an already fragile service. As an example, the last 2 week period of annual leave taken by DH involved her working for 10 days to support care during her physical absence from the Trust; Although Epilepsy12 audit results look encouraging, they only relate to newly diagnosed children and do not	8	14/03/2024	16/02/2024	13/02/2026

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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	13/01/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Need to ensure future sustainability once recovered.	[13/01/2026 16:10:03 Nicola Cornish] Discussed at Specialty Governance meeting on 13th January. There are currently 5597 patients on the PBWL. The clinical validation process is ongoing with 654 patients reviewed to date, of which 67 patients have been discharged. A non-clinical validation process is also due to commence this week. [02/01/2026 16:01:16 Nicola Cornish] Risk reviewed, no further update. [05/12/2025 11:03:28 Nicola Cornish] A new SOP has been agreed, which requires clinicians to complete 3 validations per clinic, and define a clear outcome for each patient which will then be actioned by the Failsafe team, including creation of a letter to the patient informing them of the outcome. [24/11/2025 15:49:01 Nicola Cornish] Risk reviewed, no change. Ongoing work within CBU to define next steps. [17/10/2025 13:30:43 Nicola Cornish] Paper currently being written regarding next steps and plans, number has reduced since	4	31/07/2021	30/06/2022	13/02/2026

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5016	22	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Mooney, Mrs Katy		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 'Are you sitting comfortably' scheme 4 x Daily Capacity meetings (08:00, 12:00, 15:00, 18:00) Clinical Operational Flow Policy Full Capacity Protocol National Criterial 2 Admit flowchart embedded in the ED's Introduction of "Pit stop" model. The development of a CDU in October 2024 will enable some flow from the emergency department to home for patients requiring treatment to discharge. This will be monitored through UEC improvement work to ensure area is fit for purpose. If CDU is utilised to enable ambulances to offload before 2 hours this will effect the flow through CDU.	ED Risk Tool - updated 4 times daily with an overview of the department Capacity Meetings to dynamically risk assess Monthly scorecard to track performance from both harm and constitutional standards Matrons Dashboard Datix Number of harm reviews	20/01/2026	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.	[20/01/2026 11:14:25 Rachael Turner] Risk reviewed, no current change to scoring. A new front door streaming project has begun with the introduction of the Initial Assessment Model across our UEC services at Lincoln County Hospital. The aim of this new model is to address pressures at the front door, reduce impact on ED by reducing inappropriate ED attendances, improve patient experience, and decrease long wait times for assessment and treatment. An acuity score will be used to determine pathways to care. [29/12/2025 12:55:12 Rachael Turner] Risk reviewed, no further update from previous. Risk score remains. [11/11/2025 11:14:17 Rachael Turner] Risk reviewed, the streaming project is underway with estimated completion in Dec at Lincoln then moving to Pilgrim. We are looking at replacing Manchester Triage to Acuity 1-5. Risk remains at current score. [13/10/2025 08:53:02 Rachael	10	02/09/2023	31/03/2024	20/02/2026

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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	20/01/2026	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	[20/01/2026 10:27:01 Rachael Turner] Risk reviewed, there is no change in the risk scoring. This is due to performance not showing any significant sustainable improvement. [29/12/2025 12:52:37 Rachael Turner] Risk reviewed, no further change and risk score remains at accurate level. [19/11/2025 12:30:18 Rachael Turner] Risk reviewed, no further update from previous reported in October. [30/10/2025 09:05:39 Rachael Turner] A recovery trajectory is in place to reduce 62+ day breaches to 245 by March 2026, supported by an intensive specialty-level review to identify and mitigate residual risks. Weekly Care Group Intensive Support Meetings have been established, with performance trajectories now set at Trust and tumour site level for the 28-Day FDS, 62-Day, and 31-Day standards, aligned to national expectations and local targets for backlog reduction. Since 9 September 2025, a Head of Cancer	8	31/03/2026	31/03/2023	20/02/2026

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5450	659	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	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.	-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)	19/01/2026	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.	[19/01/2026 15:04:28 Charles Smith] Risk remains unchanged. Recruitment ongoing against x1 PHb and x1 LCH vacancy. Scope for another joint post as part of EBUS/EUS. Service remains reliant on significant outsourcing model at cost to meet performance targets. [15/12/2025 09:26:10 Charles Smith] Risk remains at current level with no change for now. [17/11/2025 10:02:16 Charles Smith] Risk remains at current level after discussion with consultant body. Not comfortable to reduce risk as gaps remain on core rotas etc. [17/10/2025 15:52:01 Charles Smith] Risk remains at current level with no change for now. [22/09/2025 09:49:51 Charles Smith] Risk remains at current level with no change for now. [19/08/2025 17:01:38 Rachael Turner] Risk remains at current level with no change to risk scoring. [14/07/2025 19:07:26 Rachael Turner] Risk reviewed, no change to risk score at this current time.	8	05/06/2025		19/02/2026

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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.	04/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Exploration of creating additional capacity through redesign of clinic facilities, etc. Business case to be re-reviewed and resubmitted for investment round 2026/27.	[04/12/2025 15:42:31 Nicola Cornish] Following an external review of ways of working, a trial of an alternative was commenced at Lincoln however this ceased after a week due to a significant number of concerns that were raised. Work remains ongoing within the CBU to identify other options to increase capacity. [28/11/2025 15:25:26 Nicola Cornish] No update, further review meeting scheduled for 4th December. [21/08/2025 14:05:13 Sarah Davy] Breast was top of ICB cancer risk register last year. Service is essential for Trust to maintain 28 day FDS performance. Risk mitigated through 2025/26 as a result of fixed term ICB SDF investment. Case to be re-reviewed and resubmitted for investment round 2026/27. [18/06/2025 16:07:11 Gemma Staples] Quality Committee requested that risk be reviewed and the narrative made clearer. Risk description has been updated. [15/05/2025 14:57:15 Nicola Cornish]	4	31/12/2021	29/12/2023	04/03/2026

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5520	753	Physical or psychological harm	Caroline Landon	Landon, Caroline	Constantin, Dr Carmen		11/10/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of ULHT not having a Thrombectomy centre, we have to transport patients to Nottingham. There is a risk of transfer delays for patients with acute neurological presentation suspected to be a stroke having access to a designated thrombectomy centre for consideration of mechanical Thrombectomy. This could lead to more brain cell death, increase risk to life and ultimately poor functional outcomes/severe disability. On occasions delays have been so long the offer of intervention has been withdrawn.	Attempts to streamline pathway to hold crew bring patient to Lincoln for further transfer to Nottingham however not often successful due to pathway delays. [current acute pathway QI project] Escalating to operation centre as soon as Ambulance requested for transfer if original crew already stood down/handed over. Explored option of increasing category allocated to Stroke transfers [Currently CAT2] so far despite regional engagement Ambulance service unable to re-categorise.	Regional meetings - Integrated Stroke Delivery Network M&M meetings [local & regional] Datix incidents reported.	19/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Continue to work to streamline pathway to avoid transfer delays. Consultant Stroke Practitioner & Stroke ACP lead responsible for streamlined internal pathway – current QI project till December [Code thrombolysis/Stroke] Action 2. Develop internal processes to escalate transfer delays more quickly. Stroke CBU/Acute team to liaise with Operations department for clear escalation process. Action 3. Ongoing communications/meetings with Ambulance service. Consultant stroke Practitioner liaising with ISDN & Ambulance service [Claire] ongoing Action 4. Look to the future to develop local thrombectomy centre to ensure fair access to emergency stroke treatments for the people of Lincolnshire, reducing long-term disability, dependence of health & social services, overall reducing the socio-economic burden of stroke. – Executive responsibility for service allocation?	[19/11/2025 10:36:32 Rachael Turner] Risk presented as part of Deep Dive at RRC&C, confirmed that score is appropriate at this time. [12/11/2025 13:18:31 Rachael Turner] Risk remains, there is still a service in Nottingham but we experience delays with transfer. [19/08/2025 12:13:00 Rachael Turner] Risk reviewed, no current changes. It has been advised that other areas are struggling more than us. We are however doing the best in performance based on Nottingham audits in the region. Risk score to remain. [07/05/2025 13:05:44 Rachael Turner] Risk remains the same with no current update. We have attempted to lobby the transfer of category allocated to a 1 but this was denied by EMAS. [03/02/2025 11:05:07 Rachael Turner] Risk reviewed, work remains ongoing with no change to risk scoring. [27/11/2024 13:02:18 Rachael Turner] Risk presented at Risk	8	11/10/2025		12/02/2026

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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 to their service timely. 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 Midlands Cancer Alliance key worker policy as we cannot provide supervision to Level 2 trained staff by an appropriate Health professional.	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.	Datix Complaints Cancer Performance targets	11/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Strategic & tactical working group to come up with a plan for Level 2 Psychological 2 training, supervision and the FLO app - Sam Lewis - April 2026 ICB are completing a end to end service review for Level 4 Psychological support - Sam Lewis = December 2026	[27/01/2026 11:43:07 Gemma Staples] Risk description/controls/actions have been updated as the funding has now been withdrawn. [11/12/2025 12:24:36 Gemma Staples] An update has been received from East Midlands Cancer Alliance Centre to say that patients referred 5 months ago are now getting appointments. [14/11/2025 08:45:39 Gemma Staples] Risk remains the same. Ellie Sadler has informed me today that a meeting should be taking place next week which may provide further information as to next steps. Waiting list remains high at 16 weeks. [04/08/2025 11:07:18 Gemma Staples] Risk reviewed and remains the same. The waiting time is currently 14 weeks for this service. [06/06/2025 10:16:59 Gemma Staples] Risk approved as a 4x4 at RRC&C on the 04/06 with the request that the risk description includes that this risk has a knock on effect to our patients and staff. Risk updated and	4	07/05/2026		11/03/2026

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5533	754	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Constantin, Dr Carmen		07/11/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of being unable to provide specialist assessment and investigation to people whom have had a suspected TIA within 24 hours [in line with guidelines] this may result in subsequent stroke due to a delay in intervention/treatment. Stroke may cause lifelong disability or death.	Reviewing patients as soon as we can in clinic and arranging investigations to coincide with clinic appointment [limited to imaging slots allocated per day] We convey ambulance referrals to have patients reviewed in ED by ACP team, if adequate space was provided for rapid TIA review there could be hospital avoidance [better patient experience/reduce cost and better patient flow]	Audit delays from referral to physical review in TIA clinic – Stroke Co-ordinator/service manager Recent data provided by Vascular team reports delays to carotid Doppler scans being performed, creating less benefit from surgical intervention which may result in no intervention being completed Datix review of hospital admissions with stroke symptoms post TIA clinic referral and not yet seen	12/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Allocate appropriate facilities for rapid TIA clinic – recommend similar set up to NOTTINGHAM or alternative – SOP attached. Area to assess patients perform clinic plus access to imaging [carotid dopplers & Head imaging in a timely manner-SDEC approach] Responsible divisional/service managers	[19/11/2025 10:42:33 Rachael Turner] Risk presented as part of Deep Dive at RRC&C, mitigations to be looked at that are currently in place to look at lowering the current score. Risk to be reviewed and brought back to Risk Confirm and Challenge. [12/11/2025 13:16:51 Rachael Turner] This risk is to currently remain, there are currently ongoing discussions around admin staff as any losses may effect pathway. There has been an improvement we are currently between waiting within 3-5 days. [19/08/2025 12:10:50 Rachael Turner] TIA pathway has begun last week, this is in the early stages of a new process. Risk currently to remain at same score, we will assess again in November. [07/05/2025 13:03:30 Rachael Turner] Still not up and running on TIA pathway, general wait times are coming down possible due to new TIA coordinator in place. Date yet to be confirmed for TIA pathway go live.	8	07/11/2025		12/02/2026

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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.	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	18/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Need to undertake a fragile service review - Awaiting Trust new process for Fragile Service Review - Sarah Chester-Buckley - April 2026	[18/12/2025 11:14:18 Gemma Staples] Awaiting CRIG to reopen in the new financial year to submit a new business case so risk remains the same. [18/09/2025 11:19:33 Gemma Staples] Further investment is still required to remedy this risk. [18/07/2025 11:00:02 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present therefore risk remains the same. [16/04/2025 10:05:30 Gemma Staples] Vacancy control now in force within the Trust, CRIG not excepting Business Cases which are not funded by charitable funds therefore unable to proceed at present. [20/01/2025 10:33:02 Gemma Staples] Business case now not going to CRIG, needs to be taken through Divisional PRM for funding, awaiting next meeting. [18/10/2024 10:37:20 Gemma Staples] CoN written to be submitted	4	31/03/2023	31/03/2023	18/03/2026

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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 pro-active input either in the form of	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	[23/01/2026 13:38:47 Gemma Staples] As of January 2026, we now have six substantive full time Consultant Microbiologists in post. Dr Priyanka Chaskar joined on 24 October 2025, and Dr Sawsan Awad commenced on 5 January 2026. All previous locum roles have now ended. Despite this improvement in stability, our current 6 WTE establishment remains insufficient to meet the service demand across ULHT and NLaG (combined bed base >2,000) and community diagnostic support across Lincolnshire. We are therefore undertaking an establishment review, which has confirmed that 6 WTE does not provide the capacity required for safe, sustainable infection services. As a result, limitations continue in our ability to consistently provide proactive ward reviews, timely call backs, routine education, guideline updates, and detailed antimicrobial consumption oversight. While the Antimicrobial Team provides essential support, this cannot replace	4	30/11/2025	01/06/2025	23/04/2026

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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.	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.	17/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	1. Use of tamper proof boxes/trays being purchased - April 2026 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	[17/11/2025 11:51:43 Lisa Hansford] 3 labour theatres will be audited in Dec 2025 - LH [20/08/2025 10:07:58 Rachael Turner] Risk discussed as part of the RRC&C Deep Dive, conversations have started with the anaesthetic team. Policy is being in looked at to be in line with national guidelines. Looking at closing this by end of January. Key will be monitoring compliance. [19/08/2025 14:37:49 Lisa Hansford] MSO in discussion with clinical team to explore opportunities for improving safety and security of process. [19/06/2025 10:46:19 Gemma Staples] Our plan is to audit current practice, complete risk assessments, confirm boxes to purchase for them, review any other mitigations that arise, agree with Chief Pharmacist the way forward and monitor through S&S - Completion date August 2025. [10/04/2025 09:48:32 Lisa Hansford] Escalated to SPMM for progress update.	4	30/09/2022	31/03/2023	17/02/2026

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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 CNST year 7 due to business case for	• 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.	04/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Conducting a full audit of triage cases from the past three months to identify trends and assess the impact of our interventions. 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.	[04/12/2025 13:27:36 Nicola Cornish] Following approval at CRIG, the business case was put forward to the ICB however they have declined the request on 3 occasions. The short term funding for the uplift from the Trust is only until March 2026 so additional conversations are required with the ICB for service delivery plans from April onwards. [05/09/2025 14:51:44 Nicola Cornish] Business case was presented to CRIG and the uplift of 12.2WTE was approved. Awaiting formal confirmation of this decision prior to commencing recruitment. [03/07/2025 14:09:11 Nicola Cornish] Business case has been written and seals of approval obtained - due to be presented to CRIG on 29th July and then submitted to the ICB for values framework assessment. [30/04/2025 14:25:13 Nicola Cornish] There is a continued risk due to current establishment vacancy. Additional shifts are being picked up by substantive staff to fill current templates, further recruitment is	4	30/06/2025		04/03/2026

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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	19/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case developed for the purchase of a 3rd ultrasound machine.	[19/11/2025 09:46:52 Rachael Turner] Risk presented at RRC&C meeting 19/11/2025 number of people being scanned and capacity has increased significantly. Scans can not be outsourced. Risk validated for increase in score 4x4:16 High Risk. [06/11/2025 13:49:16 Nicola Cornish] Increase in risk score has been approved by cabinet. [06/11/2025 13:48:53 Nicola Cornish] Risk description, mitigations, actions and scoring reviewed fully with Mr Arya and Justine Judd. When the risk was raised initially, this was scored in relation to service disruption and the patient harm element was not accurately reflected. The risk description has now been updated to reflect the severity of patient harm which may result from delays in scans. Some of these patients are AAA patients awaiting follow up scans and if their scan is delayed there is a risk that deterioration is not identified and the aneurism could rupture, which is	16	31/08/2021	30/04/2023	19/02/2026

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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	[30/01/2026 10:39:47 Rachael Turner] Mitigation remains-no change to scoring. [29/10/2025 15:50:21 Rachael Turner] COO has reviewed and asked if this risk can please move from Group COO to Group Chief Medical Officer. [19/06/2025 22:55:24 Gemma Staples] Risk reviewed and reworded. [17/04/2025 10:21:23 Rachael Turner] To mitigate this risk we continue to seek advise with colleagues in Nottingham. This risk continues to be monitored [15/01/2025 13:41:06 Rachael Turner] Risk reviewed, due to being able to seek advise from other colleagues at Nottingham and it not being a clinical requirement this likelihood score to be reduced. Therefore risk score to be reduced to 2x4:8 Moderate. this risk to be presented at February RRC&C meeting. [02/09/2024 17:26:56 Gemma Staples] Risk agreed to sit under COO - now amended	4	01/10/2021	31/07/2023	30/04/2026

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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 external sounds. Paediatric room layout reviewed to	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.	15/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Audiologists to take time out of clinical work to review, revise and complete the required documentation. Locum Audiologist in place to reduce backlogs of clinics - Michael Woods - December 2028 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	[15/12/2025 10:11:43 Gemma Staples] Additional space identified at Lincoln site, potential room for Grantham paediatric Booth and forward movement on Boston CDC to work with Estates to look at additional facilities. Recent E&Y review identified additional paediatric team staffing required. Current Vacancy out to interview with potential for training additional paediatric post if suitable or to back fill adult service to free additional clinics for paediatrics team if facilities are funded. Risk to Quality standards and Accreditation still high due to additional impact of RTT and DM01 recovery targets on the demands of the service [18/09/2025 13:21:22 Gemma Staples] No possibility of providing sound proofing to standard for Pilgrim site rooms, Grantham space identified for additional Booth, funding case to be developed, funding source required with appropriate staffing. Potential inclusion for Boston CDC to provide	4	31/03/2026		16/03/2026

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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	01/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written and awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Development of SPC SOP, job plan for CNS & business continuity plan - Jill Edwards - March 2026	[01/12/2025 13:36:39 Gemma Staples] Locum Consultant appointed for 1 year, end date May 2026. Funding approved for 1 year. We have had 15 hours Band 7 budget repurposed to allow for 22.5 hour CNS post. [08/09/2025 14:54:31 Gemma Staples] Increased absence within SPC CNS and annual leave with no headroom in budget has made staffing challenging and frequently left gaps where there is no face to face service on 1 or more sites. Concerns escalated and best contingency put in place to support most urgent need however, additional risks associated with remote cover only e.g. having to give remote advice and not review patient or have MDT approach to their care. [02/06/2025 16:27:49 Gemma Staples] Education delivered to Palliative champions, Internationally educated nurses and now supporting HCSW band 2-3 training. SPC team working towards being recognised as fragile service. Awaiting new	4	30/12/2024		02/03/2026

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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 was successful for a 1.0 WTE band 6	At present there is one 1.0 WTE VAN (band 6) and two 22.5 hours HCSW (band 2) covering: - Lincoln clinics (in patient only) Monday (up to and including 6 patients) and a Wednesday out/in patients - Pilgrim clinics Tuesday and Thursday, both in and outpatients - All clinics have slots for up to 6 patients, however, many late referrals are received and the clinic can increase to anything up to 12 patients. This means that the VAN goes home late most nights that incurs overtime payment. This additional activity is driven through urgent care pathways and is reliant upon a stretched team to meet this demand. As services enter a a post COVID climate there has been a recognised increase in complexity of presentations due to non-presentation at an earlier point. Case of Need has been written with final finance input outstanding to then go to CRIG ACPs are trained in this procedure but should not be relied upon as takes away from other core duties and is not a sustainable. Interventional Radiology is picking up some activity although this exposes patients to radiation and is not a sustainable option. This also require anaesthetics and theatre resources	Volume of requests against number of staff and time taken to acquire IR1 submissions - started to see an increase in incidents being reported.	27/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business case established with final finance input outstanding to then go to CRIG 6 month secondment for a PICC nurse has been advertised and will require training Give consideration to training of a wider network of clinicians associated with their individual service needs	[27/11/2025 14:02:04 Nicola Cornish] Risk remains the same. A business case is currently being written. [23/09/2025 15:08:52 Nicola Cornish] No further progress, a business case is required for expanding the team. [05/06/2025 14:45:39 Nicola Cornish] Discussed at specialty governance meeting on 4th June. New substantive nurse started last week and has a 3-6 development plan to learn how to insert PICCs so increased capacity will not be available until after she has been signed off for this and an additional HCA is in place to support her. Need to relook at the business case and how this can be progressed. [24/03/2025 12:39:14 Nicola Cornish] Discussed at specialty governance meeting on 12th March. JJ advised that they have received funding for a further PICC nurse, permanent post. Interviews tomorrow for this. [05/12/2024 10:30:15 Nicola Cornish] Discussed at speciality governance meeting on 5th December. Still waiting for business case to be	1	01/06/2023		27/02/2026

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4789	32	Service disruption	Caroline Landon	Landon, Caroline	Venugopal, Mr Vinod		16/01/2022	20	Medicine	Cardiovascular CBU	Cardiology		As a result of ongoing pressures to clinical staffing shortages this has led to a 40% reduction in the DMO1 performance. Clinical staffing shortages have been impacted by maternity leave and lack of agency staff being available for eight months. The Trust is currently unable to fund seven day echo despite this being an NHS England requirement. The Recruitment and Retention package has not been renewed which impacts ability to recruit staff. We have been unable to staff complex Echo Lists as cardiology staff are excluded from recent band 3 uplift. Length of stay for patients is increasing due to lack of cover. In addition we have recruited four new admin posts, however it will take around 3 months until fully trained which leads to delays in processing internal and external requests. Skegness CDC opened in November, however this can only be covered by admin 5 days a week which limits capacity.	Weekly review and monitoring of OP activity /utilisation data Monthly data provided throughout CBU to review performance; secure any additional available capacity Escalation through CBU and Divisional governance processes / Planned Care Cancer and Diagnostic System Recovery Cell All referrals are triaged to ensure appropriate	DMO1 activity - monthly review Backlog consistently increasing. Booking Team are now part of the Cardiovascular Division.	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	[21/01/2026 17:10:09 Rachael Turner] No further funding has been received, position remains at this level with the concern the DMO1 performance will start to dip from Jan-end of March. ICB are aware of this. [31/10/2025 14:20:18 Rachael Turner] ICB have funded a further 2000 scans to maintain service provision at community diagnostic centres until end of financial year. Risk score to remain due to shortage of Cardiac Physiologists and lack of seven day inpatient service as is required to maintain level three acute services and PPCI service and have an emergency department. Current outpatient demand exceeds capacity. [04/08/2025 08:42:18 Gemma Staples] Below should state 4x4(16) and not 4x4(12) [23/07/2025 15:33:27 Gemma Staples] Risk increase 4x4(12) presented at RRC&C 23/07 and approved. [07/07/2025 11:37:01 Rachael Turner] Risk is being presented at Risk	4		01/02/2024	21/04/2026

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4646	66	Physical or psychological harm	Caroline Landon	Landon, Caroline	Gibbins, Donna	Patient Safety Group	14/12/2021	20	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	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	30/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Delivery of the NIV Pathway project as part of the Improving Respiratory Service Programme within the Integrated Improvement Plan (IIP): 1. Understand the Trust-wide demand and capacity for Acute and Non Acute NIV. 2. Provision of ring-fenced beds for NIV. 3. Develop Trust-wide Model and Pathway for Acute and Non Acute NIV To meet BTS/GIRFT Standards. 4. Provision of NIV service (ED) which meets the BTS Quality Standards. 5. To have a trained workforce with the skills required to meet the needs of the patients and BTS standards. 6. Governance Process for NIV Demonstrating a Safe Service where Lessons are Learnt.	[30/12/2025 11:00:32 Rachael Turner] Risk reviewed. risk remains at current level. [24/09/2025 09:28:31 Rachael Turner] Risk continues to be monitored with accurate controls. No current change. Risk score remains at current level. [12/06/2025 10:19:08 Rachael Turner] ED still not following process which is going outside of safety measures, which causes a negative effect on the NIV audit. This remains to be at both Lincoln and Pilgrim but more so at Pilgrim, Patient safety incidents continue to be reported around appropriate usage, equipment, exclusion/inclusion criteria for treatment, ongoing monitoring and usage of an already robust NIV pathway to Respiratory teams. A study day was put on for ED staff, however not been able to move forward as for national standards they need to be exposed to starting off NIV and have a competency. ED are currently looking into how they	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 priority for relocation to a safer	[15/01/2026 15:46:02 Rachael Turner] Reviewed with Karen Bailey, no change to risk [06/10/2025 15:49:49 Rachael Turner] Risk reviewed 06.10.25, no change to risk [18/07/2025 11:41:52 Gemma Staples] Risk reviewed and there is no further update, however attached to the risk are the latest action plans and reports. [04/03/2025 10:56:23 Rachael Turner] Work remains ongoing. Ventilation Safety Group is now set up and regular audits and actions are produced and monitored to support and find solutions for ventilation issues. [19/11/2024 12:16:52 Rachael Turner] Risk action plan remains ongoing. Estates and capital are working towards replacement. A meeting is booked on the 9th December to discuss capital funding. A new ventilation safety group has been put together, chaired by head of estates. Audits and actions are being produced to find solutions for	8	18/07/2025		15/04/2026

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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 via GAU Patient information around signs and symptoms to be aware of and who to contact for advice and help. Offer scan capacity at either site. Review of referral criteria along with Lead EPAU Consultant. Weekend scanning where possible if agreed within Division as overspend to support to reduce demand. EPAU nurse currently undertaking sonography course to support improved scanning availability and efficiency within the service.	Complaint data PALS enquiries Patient and staff feedback	05/12/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Requirement for nurse-led sonography is being considered within the Gynaecology TNA currently being undertaken. Need a 7 day service at each site but plan is to increase capacity by one day at first. Explore utilisation of CDCs to support scan delivery - this will also assist with the separate risk of patients who are potentially losing their baby from having to access care in Maternity areas where there are heavily pregnant women and babies.	[05/12/2025 11:16:22 Nicola Cornish] The EPAU nurse has completed her sonography training and is now undergoing a preceptorship period which is due to end in March 2026. There is still only funding for 0.8WTE EPAU nurse at each site. [26/09/2025 09:23:58 Nicola Cornish] The EPAU nurse is currently undertaking ultrasonography training and once completed this will provide some additional support however this will not fully address the capacity issues. [30/04/2025 14:59:50 Nicola Cornish] Discussed at RRC&C meeting on 30/04. RCOG recommend patients are seen by EPAU within 24 hours of referral however our current wait time can be up to two weeks. This delay can cause permanent physical harm as well as psychological harm eg if an ectopic pregnancy is detected early, fallopian tube saving medication can be used but late diagnosis results in tube removal. Reviewing EPAU criteria to minimise when scans are essential to protect	4	31/05/2025		05/03/2026

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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.	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	[15/01/2026 11:03:52 Lisa Hansford] Quarterly audits completed in Oct 2025 and Jan 2026 audits in progress. New risk for medicines management in development. [09/12/2025 14:21:54 Lisa Hansford] Rolling audit program in progress, action plan and audit trail established. Safer Medicines initiative Group (SMIG) established. [02/10/2025 11:02:13 Lisa Hansford] SOP for ward pharmacy staff visits completed and approved at pharmacy governance. Safe and secure audit tool has been reviewed and updated. [20/08/2025 10:11:58 Rachael Turner] Risk presented as part of RRC&C Deep Dive, we are hoping to get traction on this risk and once changes embedded we will look at closing and creating a new risk around ward areas. We are making sure we are engaged with all Quality process of medicines management in place. Audits are being looked at across the Group that they are fit for	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 inadequate staffing and inadequate space and an increase in available treatments particularly oral treatments, SACT capacity does not meet the demand required which would lead to the Trust being unable to meet our 31 and 62 day cancer targets, psychological distress to patients due to waiting time and staff burn out due to working conditions. Pilgrim does not have a medical day unit (MDU), our SACT services therefore have to run differently to Lincoln. Chemotherapy Suite at PHB has 18 Chairs which could all be utilised for SACT delivery however, as we do not have an MDU these are used for transfusions, picc flushes etc.	OAU used in appropriately at times, patients admitted to wards if time critical. Staff work extended hours Patients waiting 3 weeks or more are escalated to Matron	Datix incidents Complaints / PALS Staff concerns Sickness absence Retention figures 31 & 62 day targets	22/12/2025	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	[22/12/2025 08:56:37 Gemma Staples] Risk reviewed and remains the same. We are looking to open the SACT CDC room at Skegness which will help. [29/09/2025 14:06:27 Gemma Staples] EMCA benchmarking shows Chemo Suite Needs 14 WTE RN per day and Ingham Needs 17.5 WTE RN – we currently do not have this staffing. Chemo suite Requires additional 100 clinical hours at present to deliver care and Ingham Requires additional 250 clinical hours at present to deliver care per week for what we currently are delivering. [26/09/2025 13:32:45 Gemma Staples] Waiting for establishment review update, waiting for SACT room at Skegness CDC which will help. [17/09/2025 14:12:35 Gemma Staples] Risk approved in the increase of scoring to a 5x3(15) at RRC&C on 17/09/2025. [27/08/2025 13:10:43 Gemma Staples] Risk reviewed against the scoring matrix as a Physical &	6	23/05/2024		23/03/2026

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5146	277	Physical or psychological harm	Caroline Landon	Upjohn, Emma	Marshall, Lisa		13/04/2023	9	Family Health	Women's Health and Breast CBU	Gynaecology		As a result of insufficient scanning capacity, the termination of pregnancy service is currently unable to meet RCOG standards resulting in reduced patient experience and potential psychological harm. This is also a reputational risk to the trust due to non-compliance with standards.	Matron working with the ICB to look at improvements, Undertaking patient feedback requests and questionnaires to ascertain patient's voice to improve service. Home termination of pregnancy implemented, next steps to look at implementing tele medicine service which will potentially reduce the need for scanning of all patients, however reliant on patients knowing LMP and having a regular cycle.	Monitoring number of patients unable to receive service at the trust and have to be referred elsewhere.	05/12/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Full implementation of at home termination of pregnancy service including audit of services to understand if patients under 9 weeks can safely have a termination of pregnancy without a scan. Meeting with commissioners to ensure understanding of patient experience and how to improve service moving forward.	[05/12/2025 11:30:01 Nicola Cornish] We are proceeding with discussions regarding implementation of telemedicine, with guideline group due to meet today to discuss this. [26/09/2025 09:24:51 Nicola Cornish] Lisa Marshall is completing the ICB weighted value framework template to request additional funding but meeting the required level to be considered at panel is challenging. The guideline for implementation of telemedicine is also being review but additional staffing would be required to deliver a robust level of service. [30/04/2025 14:49:17 Nicola Cornish] Discussed at RRC&C meeting on 30/04. The referral to assessment wait is currently 3 weeks, against a standard of 5 days, with a further wait for subsequent treatment. As terminations within ULHT only done up to 12 weeks, this delay is significant as it decreases the options open to patients - prior to 10 weeks, TOP can be done in the patients own home but after this has to be done in hospital and may require surgical	3	29/02/2024		05/03/2026
Strategic Objective							**1a (ii) Improve patient experience**																			

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4731	33	Physical or psychological harm	Caroline Landon	Landon, Caroline	Landon, Caroline	Safety Group	13/01/2022	20	Corporate	Chief Operating Officer	Operations - Acute	Trust-wide	If patient records are not complete, accurate, up to date and available when needed by clinicians then it could have a widespread impact on clinical services throughout the Trust, potentially resulting in delayed diagnosis and treatment, adversely affecting patient experience and reducing the likelihood of a positive clinical outcome.	- Clinical Records Management Policy (approved June 2021, due for review December 2023) - Trust Board assurance via Finance, Performance & Estates Committee (FPEC); lead Information Governance Group / Clinical Records Group - Now led by Deputy Medical Director.	Internal audit of medical records management processes - reliance upon hard copy patient records; patients may have multiple sets of records. Reported incidents involving availability of patient records issues.	16/01/2026	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.	[16/01/2026 10:08:36 Rachael Turner] No change to current risk position. Currently chasing with Health records for ownership of risk. [17/12/2025 11:49:31 Rachael Turner] Risk reviewed, although no current change discussion was had whether this risk should sit with Health Records-clarification to be sought and update to be provided. [21/11/2025 12:40:25 Rachael Turner] Go Live date for EDMS set for January 2026 for Neonates, Paediatrics and Community Paediatrics. There will then be a phased roll out of gradual implementation across remaining departments from Jan-September 2026. [13/10/2025 11:23:43 Rachael Turner] Request made by digital for this risk to remain open from ops perspective. [22/09/2025 09:24:09 Rachael Turner] Presenter not available for RRC&C, this will now be deferred to October meeting for closure. [13/08/2025 14:37:26 Rachael	4	30/06/2018	31/03/2025	16/02/2026

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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.	[22/01/2026 14:24:13 Nicola Cornish] Risk reviewed, no change. We are still awaiting confirmation of the preferred supplier and it has been suggested the earliest possible completion date of refurbishment work is October 2026. [23/10/2025 15:08:09 Nicola Cornish] Procurement processes are underway - we are awaiting a preferred supplier to be confirmed and it is anticipated that the refurbishment work will be able to commence soon after this. [25/07/2025 10:40:46 Nicola Cornish] Charitable funds have been requested to assist with refurbishing the room currently used to make this a more comforting environment for bereaved parents to be in. [12/06/2025 14:24:09 Gemma Staples] Quality Committee asked if the risk can be reviewed as they believed the work had been done. Emma Upjohn confirmed that the risk remains the same on the LCH site. The works are being planned, but not commenced yet. [01/05/2025 15:26:56 Nicola Cornish]	4	07/08/2025		22/04/2026

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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	[28/01/2026 15:50:59 Gemma Staples] Physics roles have now completed job matching but require updated VCP approval to go out to advert. Workforce gap analysis for therapeutic radiographers is imminent and will be shared with NHSE. [12/11/2025 14:31:59 Gemma Staples] New staffing guidance is due out soon the can be benchmarked against for staffing levels for radiographers, Physics staffing is still low so this risk is still appropriate with regards to that. Job matching for some roles is still ongoing [26/09/2025 08:58:35 Gemma Staples] Risk reviewed and reworded. [17/09/2025 13:58:27 Gemma Staples] Risk approved as a 4x4(16) at RRC&C on 17/09/2025 with the request that waiting times be included into the risk detail. [09/09/2025 10:25:14 Gemma Staples] Recruitment of 3 B5 radiographer post underway, 1 starting 15th September with 2 others going through the recruitment	4	30/09/2025		28/04/2026

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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	01/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026	[01/12/2025 14:01:10 Gemma Staples] Absence rates within the team continue to be high. All current staff successfully returned to work, flexible working processes in place, absence management policy followed. Team time out sessions continue quarterly. All staff aware of the EAP offer. The SOP that is being developed will give clear guidance to staff on a day to day basis of service requirements and responsibilities. [08/10/2025 12:36:54 Gemma Staples] SPCT staffing continues to be challenging we now have 0.8 WTE band 6 off LTS and band 7 has reduced their hours to 0.8 WTE and is on a phase return. This means we are working at a deficit of between 90 and 93 percent of the MINIMUM safe staffing for specialist palliative care as advised by the Association of Palliative medicine workforce review and is not sustainable or acceptable for patient care or staff wellbeing. We are submitting a datix when there is no CNS on site for the service. [02/07/2025 13:38:44 Gemma	8	30/12/2024		02/03/2026
Finance & Performance Committee																										
Strategic Objective													**1b: Reduce waiting times for our patients**													

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5447	691	Service disruption	Caroline Landon	Capon, Mrs Catherine	Rojas, Mrs Wendy	Workforce Strategy Group	05/06/2024	16	Surgery	Theatres, Anaesthesia and Critical Care CBU	Theatres		Nurse staffing in theatres does not support current activity, resulting in patient cancellations and delays. There is a risk of elective lists being cancelled due to lack of theatre staff. Business case has been written to source funding. Currently in a difficult position. The off framework is going to stop soon with an impact that will possibly cancel lists. Lengthy discussions have been had to support Theatres. Break Glass agency workers are starting to be put in place but we are still very short. ODP has been approved but no back fill.	AFPP guidelines for staffing in perioperative setting in place. Daily review of staffing/lists and prioritisation of patients within available capacity. Use of agency staff where required to avoid cancellations where possible.	Incident reporting Review of cancellations	26/01/2026	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.	[26/01/2026 11:13:50 Nicola Cornish] Discussed at RRC&C meeting on 26th January 2026. Staff are coming to the end of their training so there are more staff available to fully staff lists, in particular the orthopaedic lists, and there has been a reduction in the number of cancellations. The decrease in score to 16 was approved. [19/12/2025 13:29:27 Nicola Cornish] This is still ongoing but risk slightly reduced due to the use of insource external theatre teams at Lincoln site. Longline agency use now ceased. Scrub staff on rotation coming towards the end of their training to work independently in the numbers. To go to RRC&C in January for approval of reduction in score to 16. [28/11/2025 14:35:58 Nicola Cornish] Risk reviewed, no change. [09/10/2025 14:11:52 Nicola Cornish] Discussed at Anaesthetics speciality governance meeting on 3rd October. Sam Goy provided an update confirming that the Director of Nursing has given approval for 3 long-	8	30/06/2025		26/04/2026

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5267	485	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	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.	[21/01/2026 17:19:57 Rachael Turner] Risk reviewed, ongoing patient safety incident being investigated, however backlog has been alleviated but concern remains over whether this sits in Cardiology or with Radiology. [31/10/2025 14:27:15 Rachael Turner] Risk reviewed, score to remain at current time but this will be reviewed in January to review position. There are currently 42 cardiac MRI scans awaiting reporting and the oldest of these is from the 3rd October (at the time 24 days). There are also 6 Cardiac MRI scans that have been reported by Cardiology but are still awaiting co-reporting by the Radiologists. The oldest of these is from the 26th September (at the time 31 days). Radiology are utilising a company called Medica to maintain turnaround times. [07/07/2025 12:07:42 Rachael Turner] Risk remains, no change to risk score. [09/04/2025 10:54:58 Rachael	3	01/07/2024		21/04/2026

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5381	560	Service disruption	Caroline Landon	Landon, Caroline	Taylor, Lee		09/02/2024	15	Corporate	Chief Operating Officer	Operations - Acute		Discharge Lounge (DL) has insufficient substantive workforce to meet current service demands. Significant RN and HCSW WTE shortfall. No B7 manager in place. B6 jnr sister post is unfunded secondment. No ward clerk. Insufficient housekeeping hours. This means that DL cannot staff each shift witihin budget and relys on temporary workforce and inpatient ward support. RNs and HCSWs act as ward clerk and Housekeeper. The risks are:- service is not well led on every shift contributing to delays, failed discharges, reduced patient capacity and turnover, reduced patient flow impacting on front door, omissions in care, omissions in documentation, errors, patient safety incidents, poor staff wellbeing, Poor patient notes and careflow management, poor patient experience. Improvement to practice very challenged to implement due to temporary staffing. Unable to function within current budget. Reputational damage. Inability to meet CQC requirement from 2021	Each shift has substantive, bank or ward swap nurse in charge. Staffing issues on the day managed by ops matron. Shifts go to bank and then to agency. Dynamic risk assessment; capping capacity or refusing complex patients. Strategic on call sign off required to close discharge lounge due to staffing. Orientation of temporary staff; Induction materials. limited support and advice from operations centre. RNs and HCSWs complete meal and refreshment service. RNs and HCSWs complete cleaning required outside of 2hrs allocated Housekeeper time. RNs and HCSWs complete ward clerk duties.	Healthroster, Workforce safeguard spreadsheet, 8a lead audit, flo audit, datix, PALS feedback and complaints, e-mail feedback, monthly budget, CQC assurance summary, DL patient flow dashboard, daily delays escalation, complaints, PALS feedback, TSSG, Confirm and challenge process. Sickness rates.	03/02/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1)Recruiting RNs against potential agency savings as part of TSSG. 2)Case of need in progress to fund appropriate establishment to meet demand.	[03/02/2026 12:16:08 Rachael Turner] Funding has now been established to cover Discharge Lounge staffing needs. They are funded for both sites a WTE band 7, 2 WTE band 6's, band 5's at 8.24 (16.48 for both) band 4 at 2.17, 6.98 for band 3 (both) and both have a band 2 ward clerks. Discharge Lounge are currently going through QIA process to recruit the remaining vacancies that sit in bad 4/5. Due to funding for staffing in place and a smaller number of remaining vacancies risk requested to be closed. This risk will be presented at RRC&C for the February meeting. [02/02/2026 12:36:19 Rachael Turner] Risk reviewed, no current change to scoring. [31/12/2025 12:06:30 Rachael Turner] Ownership confirmed by COO to currently remain under Ops for now. Handler updated to Lee Taylor. Full review of this risk to be undertaken in January. [17/12/2025 11:28:02 Rachael Turner] Risk reviewed 17/12/2025-	4	09/02/2025		30/04/2026

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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.	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	17/12/2025	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	[26/01/2026 10:02:02 Gemma Staples] Risk discussed at RRC&C on 26/01/2026 and approved the score increase from a 4x3(12) to a 5x3(15). [17/12/2025 12:25:25 Gemma Staples] Risk approved at Cabinet and to be taken to January RRC&C for approval of increase of score from 4x3 to 5x3. Update: Recent operational changes and workforce challenges have significantly escalated the impact of this risk. The cessation of First Class mail and the vacancy freeze have led to a sharp rise in DNAs, with 2024–25 projected at 11,699—levels comparable to COVID and the LCH fire. This, combined with severe booking team shortages (20 WTE vacancies) and reduced list utilisation (70–80%), is causing delays in appointments, diagnosis, and treatment. MRI and Ultrasound performance has deteriorated, with DM01 compliance at 75% and 79% respectively (target 99.1%), extended wait times,	3	31/10/2026		17/03/2026
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 - Board assurance through Finance, Performance and Estates Committee (FPEC)	The Trust is monitored externally against an agency cap through the monthly finance return to NHSE/I The Trust monitors internally against its financial plan inclusive of specific targets for agency and bank spend by staff group The cross Trust workstreams are reported to the Improvement Steering Group The Divisional workstreams are reported to the relevant Finance, People & Activity Meeting (FPAM)	20/01/2026	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	[20/01/2026 09:09:13 Rachael Turner] The Trust's financial plan for 2025/26 includes a total agency plan of £12.7m. Against this agency plan; expenditure of £0.4m in December 2025 was £0.6m lower than planned and £1.0m lower than November (with the in-month reduction driven by data cleansing of £0.7m of shifts); expenditure YTD of £11.1m was £1.2m more than planned; the higher than planned agency expenditure position is driven by expenditure on medical and dental agency staffing being £1.7m higher than planned. Although YTD agency expenditure of £11.1m is £7.0m lower than spend of £18.1m 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	8	31/03/2023	31/03/2024	20/02/2026

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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	20/01/2026	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Robust recruitment plan International recruitment Medical Workforce Management Project	[20/01/2026 11:16:13 Rachael Turner] Risk reviewed, risk score remains accurate with no current change. [29/12/2025 12:56:21 Rachael Turner] Risk reviewed, no further update from previous. Risk score remains. [11/11/2025 11:15:07 Rachael Turner] Tier 2 remains ongoing, no current change to risk. [20/10/2025 14:07:06 Rachael Turner] All posts for Tier 2 and residents advertised for LCH and PHB ED. x2 consultants at PHB, await VCP approval. LCH consultant awaits AAC panel date. UTC GDH x1 tier2 doctor advertised due to DIS and interviews for x2 residents booked. 6 months most vacancies should be recruited too [13/10/2025 08:55:37 Rachael Turner] Risk reviewed, no change currently, mitigation remain sin place. [15/09/2025 09:10:31 Rachael Turner] Risk reviewed, no change currently. Risk score remains accurate	10	02/09/2023		20/02/2026

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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 support additional resource.	National policy: - NHS annual budget setting and monitoring processes - Breakeven Plan - Acute to Community, Analogue to digital. ULHT policy: - Detailed Financial plan inclusive of the headcount reductions has been submitted and ownership is in place for delivery. - Alignment of the Trust financial improvement opportunities with system partners to develop an integrated financial recovery plan aligned to CIP. - Development of Care Group level Schemes assured through PRM's and GLT (Transactional) - Establishment of future looking programme to develop schemes for a sustainable cost improvement programme for the future. This incorporates Acute to Community pathways across the group (Transformational) - Establishment of a suite of cross cutting schemes aligned to the Group Improvement Strategy supported by the transformational team resource. (Targeted) - Divisional CIP targets allocated as part of the budget setting process and removed from budgets. ULHT governance: - Detailed CIP reporting via the CIP tracker supported	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.	20/01/2026	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 - Additional resource supported in	[20/01/2026 09:15:40 Rachael Turner] A review of the technical delivery schemes has resulted both the bring forward of schemes from later in quarter and identification of new opportunities to mitigate the current underperformance of planned schemes. [19/12/2025 15:04:57 Rachael Turner] External recovery support has been secured at month 8 to offset 50% of the escalation bed scheme (£0.9m) and also the WOS scheme (£3m). The escalation process for care group PRMs continues and recovery actions are being implemented for quarter 4. [20/11/2025 08:52:49 Rachael Turner] Further deterioration of CIP position reported at month 7. Further confirm & challenge in month being taken to understand what the impact is on the forecast. Care Group PRM's & CIP Reviews – frequency stepped up where needed and focus on delivery of plan. Medical workforce programme reignited under CMO with targets set	4	01/04/2026		20/02/2026

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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.	19/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Requires a strategic decision from the Trust regarding a Records management lifecycle and level of expertise to advise and guide on future projects and developments. Needs to link into 365, ePR and EDMS Programme. 365 cannot be delivered with dedicated Records SME resource.	[19/11/2025 10:08:07 Fiona Hobday] Position remains the same currently. Hope for movement in quarter 4 as part of service re-design. [08/09/2025 10:56:10 Rachael Turner] Risk reviewed, mitigation remains and score is accurate [28/04/2025 14:09:57 Fiona Hobday] Is a growing area of importance due to EPR, EDMS, personnel file issues etc... Lack of an SME is a challenge. Work ongoing to look at structure and resource for a future role as part of portfolio restructures under Group. Awaiting transfer of funding from Digital projects. Decision to procure an EDMS that can't (and won't ever) include corporate records mgmt is a missed opportunity for the Trust. [29/01/2025 12:42:38 Rachael Turner] Risk discussed as part of the Deep Dive at Risk Confirm and Challenge meeting. This has started to escalated as its an area where we	4	28/06/2024	31/12/2025	19/03/2026

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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.	[20/01/2026 11:09:44 Rachael Turner] Risk reviewed, no change to risk scoring. [03/10/2025 16:28:54 Rachael Turner] We are currently working on an updated case of need for more staffing to allow us to expand into weekend days, however as CRIG will not hear anything without an agreed source of funding this is very slow going and incredibly frustrating. The deputy COO, is currently trying to find funding. A QIA has been created (with Louise Hobson from PMO) for the risks of stopping weekend working, as was requested by Nick Mulholland (Deputy Chief Nurse for Quality and Safety). This is going to be heard at the QIA panel meeting on October 14th (QIA number 2025-513) [23/06/2025 17:18:27 Rachael Turner] Currently undergoing a service review of HOOH's. They are looking at everything; what we do,	6	19/02/2025		20/04/2026
Strategic Objective								**1d: Provide modern, clean and fit for purpose care settings**																		

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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.	[22/01/2026 14:21:48 Nicola Cornish] Risk reviewed, no change. [23/10/2025 15:10:36 Nicola Cornish] Risk reviewed, no change and monitoring of impact is ongoing. Routine investigation of PPH incidents has identified areas for improvement in communication between maternity and theatre teams and steps have been taken to strengthen joint working arrangements. [24/07/2025 15:43:53 Nicola Cornish] No further update, no adverse incidents being reported. [01/05/2025 15:25:19 Nicola Cornish] Risk reviewed, no change. [24/01/2025 10:34:50 Nicola Cornish] This issue is ongoing and will remain the same until the refurbishment programme has been completed. Continue to receive patient feedback about poor experience of being moved through corridors. [09/12/2024 10:11:00 Nicola Cornish] Risk reviewed by Emma Upjohn - no further progress, still awaiting trust board decision regarding	6	01/01/2025		22/04/2026

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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 failed and was deemed beyond economical repair and	-COSHH assessments and training. -Health Safety Environmental and Welfare Operational Audit programme. -Direct involvement with Occupational Health. -Datix incident reporting.	21/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	The issues identified with exposure levels are not unique to ULHT, as with most NHS Trusts investment is required to upgrade Ventilation to comply with HTM 03-01. NHSEI issued guidance on the 2nd March 2023 for NHS Trusts to follow. Noting where ventilation is insufficient, human factors are critical in reducing staff exposure, such as: 1. Providing clear instructions to patients on correct use of equipment being used, including exhaling into the rebreather mask or out through the mouthpiece 2. Staff positioning relative to exhaust N2O and the direction of ventilation flow 3. Turning gas and air off when not in use 4. Unplugging regulators from outlets when not in use 5. Monitoring the condition of equipment for leakages. These factors can't directly be influenced by Estates and require the support and influence of Clinical Leads and Occupational Health. ULHT Health and Safety Team have recently implemented software to assist with COSHH assessments and training. The Team provide support with the	[21/11/2025 12:44:40 Rachael Turner] Meetings taken place with the Chair of MGPS, Maternity and Health & Safety. Chair of MGPS has sought advice with the Head of Occupational Health, who has advised that a occupational hygienist is required to suitably and sufficiently monitor the workplace exposure to entonox. Health & Safety team are exploring potential options and shall present to the maternity team. Additional to this an e-learning training package is being explored as well with ELOD. [06/10/2025 10:43:49 Rachael Turner] Risk has been re-drafted with a new Moderate scoring. Risk will be agreed at Estates Governance and then this risk will be presented at Risk Confirm and Challenge for closure and new updated risk agreed. [04/07/2025 13:01:35 Rachael Turner] Work currently being undertaken to review this risk for possible closure and replacement with new risk looking at estates CBU perspective. Update to be provided.	10	28/03/2024		21/02/2026

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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	20/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Working with Estates to get costings for a permanent room – Victoria Biddulph – June 2026	[20/11/2025 09:29:48 Gemma Staples] Risk reviewed and remains the same. [19/08/2025 16:07:52 Gemma Staples] Currently awaiting quotes from Estates so no further update. [29/05/2025 16:51:00 Gemma Staples] Estates have presented specification options to the Head of Service. Once requirements agreed then estates to gather quotes for works required. [25/02/2025 11:19:15 Gemma Staples] Neurophysiology had a meeting on 15/01/2025 with Capital Projects Team, awaiting further update. [29/11/2024 14:16:09 Gemma Staples] Meeting was held on the 27/11/2024 with Family Health and the risks were discussed and Simon Hallion escalated to estates stating the urgency to get this resolved. Handler amended to Victoria Biddulph. [03/09/2024 12:06:05 Gemma Staples] This has been escalated to Estates asking for an update and a	4	26/08/2024		20/02/2026

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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 - Local fire safety issues register (generated from local	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 training provision	19/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	- Capital investment programme for Fire Safety being implemented on the basis of risk - 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	[19/11/2025 11:04:26 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level. [03/11/2025 12:43:10 Rachael Turner] Full risk review carried out with updates to controls. Security Team are undertaking Hot Spot High Risk Fire Safety Checks across the three acute sites and we will implement at two UTC's (Skegness & Louth) once training is complete with security staff. [02/09/2025 13:51:10 Rachael Turner] storage of items on corridor has been highlighted with risk from arson, task and finish group to look at challenges formed. actions from group will report to FEG/FSG and FPC. compartmentation works with capital commence this month based upon risk areas [19/06/2025 10:58:29 Rachael Turner] Emergency lighting included following assurance and PPM review. new Fire group policy reviewed within FSG prior to approval. New	10	31/03/2026	31/03/2025	03/02/2026

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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 Increase in laptops provided so staff can go and work	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	04/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Work with Estates to identify better facilities – Ruth Taylor – April 2026 Business Case is required to implement any service move to another space – Rebecca Johnson – April 2026	[04/12/2025 14:36:03 Gemma Staples] Health & safety review took place 26 November 2025 as a result of rat infestation in the department. Outcome of the report is that the Estate is not fit for purpose to deliver patients clinics or for staff to work from. Currently sourcing alternative Estates with little success. Staff have been asked to hot desk and work form home. Have moved all clinics were possible to alternative space. However it is likely clinics will be required to be cancelled due to no space to deliver our services. [03/11/2025 12:27:12 Gemma Staples] Therapies and rehab med service manager working with Lauren Boden from estates team and Outpatient Therapy Service Lead to review previous information sent re room size requirements and requirements for clinic requirements across all localities based on forecasted activity requirements and current resource capacity. Walk around of dept by Lauren Boden to be completed. Draft plan for therapy	4	31/03/2022	31/03/2023	04/03/2026

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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 patient safety, regulatory compliance	1.Devices deemed to be unsafe have been removed from use at audit point and portable suction devices were made available for clinical areas use, if needed. Some filters that were not fit for use were replaced then and there. This supports operational efficiency 2.24/07 Placed urgent compliant orders to support the replacement of devices at Pilgrim Hospital, Boston. 3.17/07/2025-24/07/2025 – Negotiated discount to have a cost avoidance of £48,964.76 +VAT against NHS Supply Chain, with an annual CIP saving for the next 7 years of £13,859,34 + VAT per year, giving a total of £97,015.41 saved over this period, to address the future finance risk. 4.Engagement with key stakeholders to accelerate actions while ensuring safety and considering financial implications.	Audit Datix incidents Patient complaints / PALs Review of all equipment	17/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1: Financial resource has been identified to purchase replacement medical devices for Boston only. This should lead to replacement of all affected devices by the w/c 25 August 2025.Completion Date – August 2025 Action 2: Work is underway to raise finances needed to take mitigating action following receipt of the Lincoln audit findings. This remains a work in progress.Completion Date -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 Technicians. These roles are essential to	[17/12/2025 09:22:14 Rachael Turner] Risk Update – Potential Re-Evaluation Required The risk may need to be reassessed at Risk and Challenge due to the inability to deliver the planned actions. This is primarily caused by: •Delays in approving VCP requests to fill in-budget vacancies •Additional responsibility for managing medical gas equipment including oncalls, transferred from Estates and Facilities without any additional funding or workforce This issue has been escalated internally to the Alliance Care Group (In Dec 2025) and the Group Chief Integration Officer (Since Sept 2025), but no response has been received to date. Current Impact: •~2,500 medical devices require commissioning •~5,000 medical devices now require a preventative maintenance schedule	4	19/08/2026		17/03/2026

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5272	455	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Miller, Mrs Sally		06/10/2023	12	Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	As a result of the current Cath Labs coming to end of life and Lincoln Cardiac catheter lab not being connected to the emergency power supply at Lincoln County Hospital, power cuts and faults due to breakage may occur. This would lead to potentially being unable to offer a PPCI service (primary percutaneous cardiac intervention) and possible risk of patient harm, death or possible implications around infection if a patient is undergoing a procedure at a time of a power cut. Parts not being able to be sourced may put inpatients for angioplasty and pacing procedures at risk and cause significant disruption across the service In addition, Cardiology is trying to build a case for a 3rd lab due to lack and ability and being able to maintain emergencies and piece of work is being undertaken on lab efficiency to help inform the case for. Currently there is nowhere currently on the Lincoln site for a 3rd lab A large	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.	[21/01/2026 17:35:52 Rachael Turner] CBU working with Capital Planning, Finance, Clinical and Strategic Projects to create new business case for a replacement of the two current labs, a phased approach to create a third. [31/10/2025 15:01:44 Rachael Turner] Approval gained at CRIG for replacement of two Cardiac Catheter Labs with a view to exploring a third lab in the future if demand and efficiencies can be demonstrated. [16/09/2025 14:35:45 Rachael Turner] Risk reviewed and remains at current level. This risk to be merged with existing Cath Lab risks on register to create one risk. [13/06/2025 10:58:55 Rachael Turner] No current change, risk score remains. [12/03/2025 14:02:25 Rachael Turner] Both labs have had the switch over completed, the new technology lets the Cath Lab acquire. We need to understand how long we can acquire for, how long to charge etc. We now have machine capable	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.	[22/01/2026 14:27:49 Nicola Cornish] Risk reviewed, no change. Lincoln remains the priority for refurbishment. [06/11/2025 14:11:47 Nicola Cornish] Lincoln site- regular meetings with estates healthcare planners. Boston, will come after Lincoln refurb. [21/08/2025 14:12:43 Sarah Davy] Currently being picked up through Suzanne Nicholson and Estates work. [24/07/2025 15:28:23 Nicola Cornish] Immediate IPC actions were undertaken as required and work continues with Estates to agree the refurb configuration. [01/05/2025 15:23:40 Nicola Cornish] No change. IPC raised concerns about estate on both sites, ongoing conversations with IPC group and E&F for immediate actions to be taken. [24/01/2025 12:32:05 Nicola Cornish] no change, will remain ongoing until refurb programme is complete. [24/10/2024 15:12:06 Nicola Cornish] Risk reviewed, no change.	6	31/03/2025	31/03/2025	22/04/2026

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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	23/01/2026	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	[23/01/2026 13:58:01 Rachael Turner] Risk has been presented at Estates Confirm and Challenge, due to pipework being replaced this risk has been requested for closure. This risk will be presented at Risk Confirm and Challenge Group in February. [16/01/2026 11:45:30 Rachael Turner] Risk score is proposed to be reduced as the pipework has been replaced which has reduced the likelihood of it occurring again. (Looking to reduce to a score of 9 (3x3) - This will be presented for agreement at Estates Confirm and Challenge next week, if agreed this will be added to Group Risk Confirm & Challenge agenda for February. [16/01/2026 11:43:13 Rachael Turner] Pipework replacement in the void to reduce the likelihood. LTHW pipework has been replaced in that section and the chilled water pipework has also been replaced in that section. [09/10/2025 14:42:52 Rachael Turner] Risk reviewed, no current change. Mitigation remains in place	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	Estates Strategy 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. Many of the lifts are obsolete and	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.	17/12/2025	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.	[17/12/2025 10:10:22 Rachael Turner] Risk presented at RRC&C 17/12/2025. Validated for increase in score 5x3:15 High Risk. [11/11/2025 11:57:12 Rachael Turner] Increase to a score of 15 (5x3) following lift performance issues and availability of parts approved at Estates Governance. This risk will be presented at December's Risk Confirm and Challenge meeting. [06/10/2025 14:59:21 Rachael Turner] This risk is going to Estates Governance next week, Risk has been reviewed and proposed to be increased to a score of 15 following more frequent failures and issues with part availability. This will be presented at Risk Confirm and Challenge is November for approval. [18/07/2025 12:14:48 Gemma Staples] Further lifts (PHB tower block B/LCH Maternity lift A & GDH Tower block) have been identified for replacement for 2025/26 but await final sign as part of the capital plan. [21/01/2025 12:32:31 Rachael	6	26/06/2025		17/03/2026

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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	18/12/2025	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Action 1. Estates and Facilities take immediate action when notified of issues. Action 2. Working with the Hospital Emergency Landing Pad (HELP) appeal and Green Deck Operations, obtaining surveys for options and developing a business case to improve conditions and become compliant. Green Deck appeal have offered to fund the works required to existing pads once the plan is developed. Currently we need to review options available at Lincoln & Boston. Action 3. Once investment in place, Ops to work on Governance compliance for CAP1264 Civil Aviation standard. Action 4. Meeting to be had with Lee Taylor as we need to have an accurate recorded data process for recording when a helipad lands.	[19/12/2025 09:32:18 Rachael Turner] Paper will shortly be going to GLT on the future direction for Helipad. In the meantime risk re-aligned to David Purdy. [18/12/2025 11:46:11 Rachael Turner] Risk reviewed, no current change and risk score remains accurate. [10/09/2025 12:49:06 Rachael Turner] Paper to GLT due to be represented on 19th Sept. Grant secured for 2 helipads, complete refurbishment. Funding - annual cost for staff, maintenance etc. [23/07/2025 13:02:25 Sarah Davy] Agreed to increase in score at RRCoC 23/7/25 - 5x3 = 15 from 5x2 = 10 [13/06/2025 10:04:36 Rachael Turner] Risk reviewed, risk updated to be a regulatory compliance risk. We are currently not compliant as a Trust against the CAP1264 Civil Aviation standard for NHS Helipads due to the above concerns, design and fabric. Risk reduction plan updated to reflect current position.	3	31/03/2026		18/03/2026

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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	22/12/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Estates job logged to see if can increase air exchange to 10 - Stuart Whitehead - April 2026 Wider organisational piece of work - Karen Bailey - April 2026	[23/12/2025 11:07:46 Gemma Staples] The bone marrow biopsies continue to be completed on the Royal Eye Department. We are waiting for the decision to be made with regards to the OAU and potential building works that would give us a room with the correct compliance, therefore there are no plans at present to complete work on this particular room. [22/12/2025 08:57:48 Gemma Staples] Risk reviewed and remains the same [02/10/2025 09:00:42 Gemma Staples] Risk remains the same. Still awaiting a response from Estates. [07/07/2025 16:27:20 Gemma Staples] We're still waiting for an update from Estates regarding whether they can carry out the work and, if so, what the cost would be. This has been escalated to Sarah Chester-Buckley. [13/04/2025 18:09:12 Gemma Staples] Still waiting estates to give us a quote or if the work is possible [24/01/2025 10:04:54 Gemma	3	13/02/2025	13/02/2025	23/03/2026
People Committee																										
Strategic Objective								**2a: Enable our people to fulfil their potential through training, development and education**																		

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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	19/01/2026	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	[19/01/2026 11:36:57 Gemma Staples] Risk remains the same as last update. [18/12/2025 11:14:53 Gemma Staples] Awaiting CRIG to reopen in the new financial year to submit a new business case so risk remains the same. [20/11/2025 09:39:48 Gemma Staples] Risk reviewed and remains the same as further investment is still required. This situation will further decline in December when 2 Consultants leave the Boston site. Currently recruiting to these posts. [20/10/2025 11:06:28 Gemma Staples] Risk reviewed and remains the same. [18/09/2025 11:15:16 Gemma Staples] Meeting taken place with Stakeholders progressing left shift to GP Surgery's for low grade CLL and MGUS. [19/08/2025 08:20:43 Gemma Staples] All services are currently under review to establish if there is opportunity to left shift activity to the CDC's. The first services to be	8	30/09/2023	01/04/2025	19/02/2026

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4862	44	Service disruption	Caroline Landon	Mooney, Mrs Katy	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)	19/01/2026	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.	[19/01/2026 15:03:05 Charles Smith] Risk remains unchanged. Consultant establishment fundamentally below GIRFT recommended levels since 2019 with reliance on unfunded capacity. No invitation to bring necessary workforce investment case back to CRIG as does not meet criteria. Suggestion the left-shift could support this does not address fundamental gap between secondary care core demand and capacity. Risk set to worsen in April 2026 due to THLC activity and no identified funding source for this. A/w discussions with ICB in early Feb but may lead to risk being upgraded. [15/12/2025 09:17:34 Charles Smith] Risk remains unchanged. Consultant establishment fundamentally below GIRFT recommended levels since 2019 with reliance on unfunded capacity. No invitation to bring necessary workforce investment case back to CRIG as does not meet criteria. Suggestion the left-shift could support this does not address fundamental gap between secondary	4	30/12/2022	03/06/2024	19/02/2026

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5142	65	Physical or psychological harm	Caroline Landon	Thomson, Cheryl	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.	30/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. New rota templates signed off by finance, to be implemented Q3 2023. Recruitment ongoing.	[30/12/2025 10:35:44 Rachael Turner] Introduction of Acuity score to go live at Pilgrim February. [30/12/2025 10:34:42 Rachael Turner] Risk reviewed, introduction of of Acuity score to go live at Lincoln on 7th Jan, during in-hours may signpost to alternative pathways therefore providing assessment space for later in shift. Learning from PDSA cycles may highlight insufficient capacity within specialties therefore aiding the front door to attain addition provision. [24/09/2025 13:34:14 Rachael Turner] There is no change currently as going through consultation. Risk score to remain. [26/06/2025 09:27:15 Rachael Turner] Job planning instigated on the 12th June 25. Implementation October 25. [03/04/2025 14:10:48 Rachael Turner] Escalation to the execs in relation to tier 2 implementation awaiting next steps to proceed towards job planning. [07/01/2025 15:08:23 Rachael	9	31/08/2023	01/11/2023	30/03/2026

ID	5469
DCIQ ID	697
Risk Type	Service disruption
Executive lead	Colin Farquharson
Risk lead	Rinaldi, Dr Ciro
Handler	Chablani, Manish
Reportable to	
Opened	21/06/2024
Rating (initial)	16
Division	Corporate
Clinical Business Unit	Group Chief Medical Officer
Specialty	Medical Education
Hospital	Trust-wide
What is the risk?	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.
Controls in place	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
How is the risk measured?	Meeting reviews.
Date of latest risk review	27/01/2026
Likelihood (current)	Quite likely (4) 71-90% chance
Severity (currently)	Severe (4)
Risk level (current)	High risk (15-16)
Rating (current)	16
Risk reduction plan	Increase the workforce, investment into staff and education
Progress update	[27/01/2026 13:12:28 Rachael Turner] Risk reviewed, no current change. [16/09/2025 14:14:36 Rachael Turner] Risk remains the same, no further updates. Multiple talks with LCHS, they to remain in a difficult position to recruit because of job/budget freezes. Awaiting an update from Ashok around an update with any meetings with ULTH pharmacy department. [19/05/2025 12:04:21 Rachael Turner] Risk reviewed, no current change, risk remains at current level. [18/02/2025 15:12:47 Rachael Turner] Currently working with LCHS to have a shared Prescribing Skills Lead. The JD are ready and awaiting for LCHS to advertise from their side. Although funding may be an issue owing to the freeze on new appointments prior to May. [18/12/2024 11:06:27 Rachael Turner] Risk presented at Risk Register Confirm & Challenge 18/12/2024 this will be reduced
Risk level (acceptable)	8
Initial expected completion date	21/06/2025
Expected completion date	
Review date	27/04/2026

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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	28/01/2026	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	[28/01/2026 14:10:41 Gemma Staples] Risk remains the same currently as new staff are not in post as yet. [03/11/2025 10:34:39 Gemma Staples] VCP panel finally approved posts, gone to advert looking to shortlist shortly, training will be difficult due to limited staffing. Simon has spent the last 3 months imparting as much process knowledge and detail as possible. [17/09/2025 12:48:31 Gemma Staples] Risk approved at RRC&C on 17/09/2025 as a 4x4(16) with the request to include how many WTE we are short by, update risk of VCP approval and the additional updates Sarah provided. [19/08/2025 12:23:03 Gemma Staples] Risk approved at CSS Cabinet as a 4x4 on 19th August 2025.	4	31/08/2026		28/04/2026

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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	[29/01/2026 08:33:03 Rachael Turner] Risk reviewed, mitigation remains in place. Risk at accurate level. [31/10/2025 16:01:55 Rachael Turner] Risk reviewed, no change [04/06/2025 13:49:40 Rachael Turner] Risk reviewed at RRC&C currently awaiting for confirmation until reduction, this will be monitored and be brought back for reduction [28/05/2025 16:53:27 Rachael Turner] Risk proposed to be reduced to 3x4:12 Moderate Risk, the locum consultant did not leave, however still a risk as may leave. Risk to be presented as part of Deep Dive at RRC&C for reduction in score. [19/05/2025 12:00:19 Rachael Turner] Risk to be presented as part of the Deep dive for RRC&C in May for reduction. [18/02/2025 15:17:11 Rachael Turner] A different locum consultant in place who is the specialty lead and is delivering the teaching. Contract is reviewed on an annual basis. Risk to	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	12/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	To increase the number of clinicians in the Team by 1 extra member of staff per night-a Doctor or ACP-unfortunately there is no current source of funding for a Business Case. Currently looking into this but this is reliant on buy in from Medicine. This is an ongoing piece of work.	[22/01/2026 14:08:21 Sarah Davy] Following an action directed by the Integration Committee, a further review of risk alignment has been undertaken by the Deputy Chief Clinical Governance Officer and the Group People Officer and the risk has been realigned to the People Committee [31/12/2025 11:37:26 Rachael Turner] Risk to be reviewed by Catherine Capon. [12/11/2025 09:24:41 Rachael Turner] Hospital Out Of Hours currently has 1 FY1 Dr (from surgery) and 1 ACP, to cover the clinical needs of the patients across19 wards. We are currently working on an updated case of need for more staffing overnight, however as CRIG will not hear anything without an agreed source of funding this is very slow going and incredibly frustrating. The deputy COO, is currently trying to find funding. With Louise's help we have created a QIA, EIA and options appraisal (QIA	8	19/12/2025		12/02/2026

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
4780	74	Service disruption	Claire Low	Mooney, Mrs Katy	Constantin, Dr Carmen		16/01/2022	20	Medicine	Cardiovascular CBU	Stroke	Trust-wide	As a result of a significant deficit in stroke consultants levels due to staff leaving/ retiring and stroke service struggling to recruit substantive consultants there is a risk of not being able to maintain effective stroke provision across ULTH. From April 2025 the stroke service will have only one Substantive Consultant, upcoming retirement could result in no substantive Consultant Stroke Physicians in 2028-2029 if continue to not recruit. Reliance on Locum consultants is costly and causes instability in the rota. Locum/Agency/Bank reliance results in limited medical training & supervision for resident doctors, Registrars, ACPs and students – limiting staffing pool for the future & reduces staff experience/satisfaction.	•Utilising a regular pool of locum consultants •Consultant advert out •Attended recruitment drive at medical conference November 2024 •Consultant ACP post •Liaising with Integrated stroke delivery network [ISDN] for possible regional solutions	Datix/incidents/SJR/SI Rota Gaps Budget/costing	19/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Convert locum contacts to Bank where possible 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.	[22/01/2026 14:17:48 Sarah Davy] Following an action directed by the Integration Committee, a further review of risk alignment has been undertaken by the Deputy Chief Clinical Governance Officer and the Group People Officer and the risk has been realigned to the People Committee [19/11/2025 10:49:37 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level. [12/11/2025 13:14:05 Rachael Turner] Currently using locums whilst waiting for post to be filled and filled. We will continue to use after April but this will be at a lower number unless anything unexpected happens. [09/09/2025 13:31:59 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3A. [19/08/2025 12:25:24 Rachael Turner] Following People Committee feedback, this risk is still ongoing. Currently have two full consultants,	8	31/03/2022	01/07/2024	12/02/2026

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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	25/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Increase the workforce, investment into staff and education	[25/11/2025 10:57:09 Rachael Turner] This risk remains the same, funding from undergraduate is still available, awaiting funding and a compatible job plan from the division. [14/08/2025 15:48:30 Rachael Turner] Risk reviewed, specialty teaching fellow for HCoLL – this remains the same. [19/05/2025 12:07:47 Rachael Turner] Risk remains at current position, no change to current score. [26/11/2024 15:13:38 Rachael Turner] There are barriers within the Business Unit in terms of the JD/funding for the Specialty Teaching Fellow, which is delaying the appointment to this post. This should be a joint risk which sits with the Business Unit as we are unable to move forwards with this from an undergraduate perspective. [31/07/2024 13:26:57 Rachael Turner] Risk presented at RRC&C meeting 31/07/2024. Risk validated as a High risk score 4x4:16 High risk. [10/06/2024 15:43:27 Gemma	4	30/04/2025	30/04/2025	25/02/2026

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5480	683	Service disruption	Claire Low	Spendlove, Mrs Clare	Bursey, Sarah		05/07/2024	12	Medicine	Cardiovascular CBU	Endocrinology/Diabetes	Trust-wide	As a result of a depleting workforce in diabetes this is leading to withdrawal of ward work which is impacting on the quality of care that patients are receiving. Currently pan Trust Trust there should be eleven DSN nurses WTE and there is currently only two in post. Out of these two in post one is due to retire. There is currently three members of staff on maternity leave. Care is having to be withdrawn from ICU, DSN reviews and referrals. For Navenby Ward they are having to rely on junior medic workforce. Active in reach for ED is now limited due to lack of resources. This leads to the potential of missing patients. Staff education has stopped, if its not on ESR or online but no face to face is not currently possible due to work pressures.There is an impact of outpatient referrals, unless it is life threatening these are delayed till further notice which would lead to an increase in waiting lists. Unless patients are pregnant PUMP cannot be offered, there is currently a	-2x secondments approved and 1x secondment to be advertised -Working with Patient Safety Team looking at DKA within the ward and education. -Working with cost efficiency manager for department but yet to hear feedback.	staffing levels and service provision Datix incidents-list of Datix with insulin provided by Medical Safety Lead. Themes remain the same.	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.	[27/01/2026 13:17:03 Rachael Turner] Staffing remains unclear at present. Risk score to remain at current level. [22/01/2026 14:12:57 Sarah Davy] Following an action directed by the Integration Committee, a further review of risk alignment has been undertaken by the Deputy Chief Clinical Governance Officer and the Group People Officer and the risk has been realigned to the People Committee [08/12/2025 11:40:50 Rachael Turner] Risk reviewed, currently unclear what future looks like in regards with staffing. Risk to remain at current level. [09/09/2025 13:11:39 Rachael Turner] Risk transferred to Integration Committee and strategic objective updated to 3a. [13/06/2025 10:55:21 Rachael Turner] Risk reviewed, some members of staff have returned from maternity. Currently risk remains at current risk score. [19/03/2025 12:08:09 Rachael	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 outstanding amounts.	Currently no controls in place	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload CIP tracking Biosimilar switching targets	20/01/2026	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 - Jan 2026 Staff skill mix review and time and motion study to ensure that staff managing workload Andrew Baines - January 2026 Training of new store keeper post - Andrew Baines Jan 2026 Procurement staffing review - Fran Martinez Jan 2026	[20/01/2026 16:51:23 Gemma Staples] Store keeper has started in post. Procurement staffing review has been sent to Senior Pharmacy Management Team awaiting further update. QIA for 0.4 band 3 is still on hold as no funding (risk on Mondays and Tuesdays). Band 4 has been approved and is going out to advert currently. Potential to reduce the likelihood to a 4. To discuss at Pharmacy Governance. [09/12/2025 14:06:47 Lisa Hansford] Sore keeper due to start 22nd December. Staffing review drafted. To be finalised and circulated for comments before Christmas. [09/12/2025 13:59:00 Lisa Hansford] QIA Band 3 submitted to Alliance but need to confirm funding as was at risk posts [17/11/2025 11:39:39 Lisa Hansford] QIA for 0.4WTE B3 will be submitted. Store keeper training and assessments underway. Report from procurement staffing review in progress. Date collection for the time and motion study under way.	4	16/02/2024	16/02/2024	20/02/2026

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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	As a result of current Consultant staffing and on-call arrangements there is a single consultant covering both sites during weekend so cover limited if critically unwell patients on both sites which could lead to potential patient harm, delays in care/discharge.	Middle Grade cover in Oncology & Haematology over and above budget therefore using high cost agency. VC ward rounds are taking place if face to face ward rounds are not possible. Workforce review completed Refresher of Fragile Services Paper completed (NB there is a National shortage of Haematology consultants) Additional unfunded ST3+ for Haematologist started in August 2022	Datix incidents Complaints and PALS Outcome from Staff Survey results Financial constraints of group	19/01/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Cancer Services paper written awaiting CRIG invitation - Sarah Chester-Buckley - April 2026 Recruitment of further substantive consultants - Sarah Chester-Buckley - April 2026	[19/01/2026 11:37:26 Gemma Staples] Risk remains the same as last update. [18/12/2025 11:14:37 Gemma Staples] Awaiting CRIG to reopen in the new financial year to submit a new business case so risk remains the same. [20/11/2025 09:39:17 Gemma Staples] Risk reviewed and remains the same as further investment is still required. This situation will further decline in December when 2 Consultants leave the Boston site. Currently recruiting to these posts. [20/10/2025 11:05:38 Gemma Staples] Risk reviewed and remains the same. [18/09/2025 11:16:17 Gemma Staples] Further investment is still required to remedy this risk. [19/08/2025 08:21:39 Gemma Staples] Until there is further investment in the team the risk will remain as we are unable to staff two on call teams to cover both sites appropriately. [18/07/2025 11:02:15 Gemma	8	01/04/2023	01/04/2023	19/02/2026

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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 insufficient staffing establishment there is an inability to provide a safe and effective 7 day pharmacy service at ULTH. Current funding allows for the dispensaries to open Monday to Friday 9-5 and weekends mornings only and clinical cover Monday to Friday 9-5. As a result of this under staffing there is a risk that patients may require critical medication and/or specialist pharmacy advice over the weekend when pharmacy is closed. The Trust is failing to meet NICE NG5 Medicines Reconciliation targets and there is no pharmacy capacity to review eDDs or provide specialist pharmacy advice. All of these risks have multiple implications such as harm to patients from omitted medicines, delayed discharge from hospital effecting the efficiency of the hospital, readmission to hospital, cost pressures from use of FP10s.	Provision of an emergency supply only service on weekends between 9am and 12:30 On call pharmacy service outside of pharmacy working hours Quarterly comms to staff to remind them that that weekend service is for urgent items only and what the cut off time is and that we cannot do MDS.	Staffing levels / budget benchmarked against other similar trusts. Reported medication incidents occurring out of hours. Monitor sickness rates following weekend working Staff Survey results Staff exit interviews	15/01/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	QIA to be developed - LMM (Chelsea Andrews) - Feb 2026 Risk to be redeveloped - LMM Feb 2026	[15/01/2026 09:46:21 Lisa Hansford] Weekend working change awaiting presentation to GLT. QIA in developments on impact of covering ED. New risk in development which will replace this risk to ensure clarity on staffing risk in relation to establishment [09/12/2025 14:10:10 Lisa Hansford] Weekend working change impact being monitored through QIA panel and to be presented to GLT [19/11/2025 09:35:50 Lisa Hansford] Workforce review presented to GLT. Work ongoing [21/10/2025 10:41:15 Lisa Hansford] Business case on hold until pharmacy workforce review has been completed. [22/09/2025 15:23:07 Gemma Staples] Reports for the ED and Discharge Lounge Pharmacy Pilots complete and sharing reports with CSS, ED and also MQSG. Further actions to be developed from this including opportunity for winter pressure funds Monitoring of the change to weekend	4	29/10/2021	21/06/2023	13/02/2026

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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	16/01/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Recruitment to vacant posts.	[23/01/2026 11:31:27 Nicola Cornish] Risk reviewed at specialty governance meeting on 16th January 2026. No further update currently. [26/09/2025 15:10:25 Nicola Cornish] Risk reviewed, no further update. [04/06/2025 13:55:04 Nicola Cornish] Discussed at RRC&C meeting on 4th June. This risk has been ongoing for some time and it is recognised that there is now a need to look at alternative staffing options to mitigate the risk. As such recruitment is now underway for CESR (Certificate of Eligibility for Specialist Registration) trainees. [15/05/2025 10:38:01 Nicola Cornish] Recruitment is ongoing, with interviews scheduled for July. [21/02/2025 13:00:38 Nicola Cornish] Risk reviewed, no change. [11/09/2024 14:27:43 Nicola Cornish] Risk reviewed, no change. [14/06/2024 13:17:32 Nicola Cornish] The JD has now been approved and the consultant post is currently out to advert. [28/05/2024 14:47:03 Nicola Cornish]	4	31/10/2022		16/04/2026

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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.	04/12/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	To seek agreement to be able to recruit to maximum within allocated budgets – Ruth Taylor – January 2026	[04/12/2025 15:34:25 Gemma Staples] QIA completed to be heard at panel on 9th December. Asked to utilise Therapy budget underspend to reduce risk identified. [09/10/2025 11:39:13 Gemma Staples] Risk reviewed and remains the same. Declined request for additional winter funding to increase Therapy capacity to support additional acute beds eg 7A at Pilgrim. [08/08/2025 08:38:10 Gemma Staples] Following the request to review if the risk can be reduced from the People Committee deep dive. The risk owner confirmed that the rationale for not reducing is related to therapies still supporting areas where there is now increased resource allocated, this isn't likely to change as we go into winter eg escalation beds, the Lancaster ward project. We also need to complete workforce review piece of work. I would envisage that once that is done, we could then reduce the risk. I wouldn't want to reduce until we	9	30/09/2023	18/12/2023	04/03/2026
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	Mooney, Mrs Katy	Smith, Charles		19/12/2024	16	Medicine	Specialty Medicine CBU	Neurology	Trust-wide	As a result of the retirement of 50% of the substantive workforce in Apr 2025 and a challenging national recruitment environment; there is a risk that the trust's Neurology service will cease to function sustainably. This would lead to a risk of harm to patients via delayed outpatient appointments, delayed inpatient reviews and an inability of the service to meet it's demands. Prior to the impending retirement, the Neurology service is already in a situation whereby substantive capacity does not meet recurrent demands on the service At present Neurology has 5900 overdue patients on its PBWL, 44% of which (2415) are overdue by more than 1 year. At this time there is no clinical capacity (for all the reasons highlighted in this report) for any clinical validation of this backlog and no available administrative resource for a data cleanse. It may be some of these patients no longer require	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	04/02/2026	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.	[04/02/2026 13:26:41 Charles Smith] Fundamentally unchanged. Neurology moving to alliance care group, represents significant further risk given current lack of sustainability in model/size of specialty and uncertainty re: management for the future. ICB cluster/changes and current financial landscape means meaningful discussions cannot progress. Service to go to Quality committee in Feb for discussion. [19/01/2026 15:07:24 Charles Smith] No update, risk remains at previous level. A/w opportunity for discussions re: future of service with commissioners. [15/12/2025 09:20:11 Charles Smith] Working back at establishment via agency but significant backlog, unmanageable PBWL and severely under-resourced sub-specialty teams. Unable to meet elective care targets without continued insourcing at cost, YMS in place a/w extension into January. [17/11/2025 10:00:23 Charles Smith]	8	19/12/2025		16/03/2026

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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.	03/02/2026	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	[03/02/2026 13:32:27 Rachael Turner] Risk reviewed, actions remain ongoing. Controls remain in place to support mitigation of this risk. Risk score remains at accurate level. [20/01/2026 17:54:05 Helen Shelton] Update from risk handler - All 4 actions remain in place with oversight via the relevant reporting groups. Risk remains at current score of 20 whilst mitigations being worked through through the ongoing Group / Transformation programmes of work. [15/10/2025 10:41:00 Rachael Turner] Risk presented at RRC&C 15/10/25, risk validated as 5x4:20 Very High Risk.	12	31/03/2026		03/03/2026

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4778	94	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	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 assessments	SNNAP data scores . Service provision not in top quartile	19/11/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Stroke pathway development project on place. Close partnership working within community to expedite discharges into the community	[19/11/2025 10:48:40 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level. [12/11/2025 13:24:02 Rachael Turner] We continue to struggle with lack of beds in community which causes long delays, from five up to thirty days. Training has been offered to communicate to educate what we offer as a stroke service. [19/08/2025 12:14:43 Rachael Turner] We are planning by April 26 to adjust Navenby and move stroke there, this is ongoing work so risk to remain at current level. [07/05/2025 13:07:54 Rachael Turner] We are currently undertaking a project called Clear which is looking at the whole stroke pathway (acute & community) with an aim for patients getting appropriate access-as and when needed. This is due to close in September. [03/03/2025 13:05:35 Rachael Turner] Risk discussed as part of the Cardiovascular Deep Dive at Risk	6	31/03/2025	28/02/2023	12/02/2026

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5598	853	Physical or psychological harm	Caroline Landon	Landon, Caroline	Constantin, Dr Carmen		19/02/2025	20	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	As a result of the consolidation of stroke services and acute service demands there has been occasions when patients requiring admission to the hyperacute stroke unit [HASU] have not had access due to capacity issues. The HASU is often full and patients are stepped down when stable enough to enable new admissions. There have been occasions when no patient is suitable to step down therefore acute patients have been admitted to the ward area resulting in non-hyperacute monitoring due to differing staff levels and skill-mix/competences. This has been identified as a risk to patients as deterioration may be missed resulting in death or further disability.	•When HASU overspill happens, acute patients are cohorted in a bay area within the stroke unit, additional staffing is requested for increased patient acuity and monitoring requirements, staff with the most appropriate skills will be allocated to the additional acute cohorted patients. •Medical staffing 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 into or stay in HASU and other acute	[21/01/2026 17:08:12 Rachael Turner] Risk reviewed, locums are covering current gaps. No current change to risk, score remains. [21/10/2025 14:09:33 Rachael Turner] We are in the process of approving new 2nd nurse for the night shift in HASU. We have successfully recruited two consultants, one begins 30th October, the other in April 26. Risk controls updated to reflect current position. Risk score remains accurate. [07/07/2025 11:35:34 Rachael Turner] Risk reviewed, risk remains at current level with no current change risk score. [30/04/2025 13:15:22 Rachael Turner] Risk presented at RRC&C 30th April 2025. Due to current actions in place with ACPs, consultants skill mix this will take the score 4x4:16 High Risk.	8	31/03/2026		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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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)	[28/01/2026 08:19:41 Rachael Turner] Risk still remains in the current level [15/10/2025 10:34:12 Rachael Turner] Risk presented at RRC&C 15/10/25. Risk validated as 4x4:16 High Risk	8	31/03/2026		28/04/2026

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5535	784	Physical or psychological harm	Caroline Landon	Mooney, Mrs Katy	Constantin, Dr Carmen		07/11/2024	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	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.	There is currently no commissioned post for this service within the acute service there is limited provision in the community.	SSNAP data & Datix	19/11/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Commission post and recruit to post, currently lies with CBU Proposal for additional ward space	[19/11/2025 10:53:53 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level. Need to look at possibilities in wider stroke services looking for solutions for this risk. [12/11/2025 13:19:53 Rachael Turner] Risk remains the same, the earliest appointment is beyond 12 months. [21/10/2025 14:18:29 Rachael Turner] This risk remains ongoing as we do not have a clinical psychologist. We are in contact with local psychology team regularly around this and also in conversation with Leicester for guidance. [07/07/2025 11:44:37 Rachael Turner] Risk reviewed, no current change. Risk score to remain at current level. [11/04/2025 14:16:37 Rachael Turner] Risk reviewed, business case has been updated to include recommended staffing level of neuro psychology for acute and community services. Business case is due to go to	6	07/11/2025		12/02/2026

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5169	60	Physical or psychological harm	Caroline Landon	Constantin, Dr Carmen	Constantin, Dr Carmen		09/05/2023	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	As a result of consolidating the acute stroke services at one site without appropriate stroke therapy staffing & bed base, many stroke inpatients reside outside the stroke unit as outliers and do not receiving the adequate level of therapy input in line with guidelines and patient-centred care, the effect is increased risk of mortality and long term disability, as well as low staff morale and poor staff retention. There is a risk of an increase of delays to patient care, causing harm and reduced functional outcomes/recovery for stroke patients. Current mitigations mean patients on the Stroke Unit may also receive less therapy input in an attempt to deliver some input to outliers.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment. Cohort some outlier	SSNAP data Datix Complaints Staff retention & post vacancy	19/11/2025	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	1) Recruit stroke therapists [PT/OT/SALT/Dietician] consistent with current service demands in line with guidelines - Ruth Taylor - December 2025 2) A Consultant AHP post to provide leadership and stroke pathway oversight needed across the group [this has been in development since 2024 but yet to be recruited to.] - Ruth Taylor - December 2025 3) Expand Stroke bed base with funded therapy posts in line with Stroke Guidelines to reduce risk, reduce length of stay and deliver the 'centre of excellence' the population of Lincolnshire were promised - Ruth Taylor - December 2025 4) Refurbishment and workforce development – business case to be submitted - Rebecca Johnson - March 2026	[19/11/2025 10:56:04 Rachael Turner] Risk presented at Risk Confirm and Challenge as part of Deep Dive. Risk remains at appropriate level. [12/11/2025 13:21:36 Rachael Turner] Risk remains, more disabled patients are outlines and this effects visibility of these patients as they are not receiving specialist care and it is effecting patient outcomes. [06/10/2025 15:24:49 Gemma Staples] Risk reassigned to Stroke / Medicine. [04/08/2025 09:23:02 Gemma Staples] The Consultant AHP post has been appointed, work continues in regards to increasing bed base and staffing levels, currently the risk continues. [12/05/2025 13:29:49 Gemma Staples] I believe the Consultant AHP job has been out to advert and shortlisted, interviewing still to take place. [05/02/2025 10:03:18 Gemma Staples] This risk is ongoing, work continues to expand the stroke bed	3	13/05/2024		12/02/2026
Strategic Objective								**3c. Enhance our digital, research and innovation capability**																		

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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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.	[23/01/2026 10:46:11 Rachael Turner] Following collective review the digital team determine that this overarching risk remains a 16 due to the combination of risks that contribute to this higher level risk. The individual risks that support this risk are being regularly updated and contain the detail around the specific actions and mitigations resulting in an overall reduction across a number of risk areas but due to the significance of a digital infrastructure event and the impact on Trust operations, this risk continues to be managed at current level. At this time there is a substantial amount of work being undertaken which is reflected in the downward trajectory indicating that by the end of this financial year (25/26), work will have completed to a point where this overarching risk score will begin to reduce. [13/10/2025 12:35:08 Rachael Turner] Following collective review the digital team determine that this overarching risk remains a 16 due to the combination of risks that	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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
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.	[23/01/2026 10:26:40 Rachael Turner] While work to mature the Group backup capability continues, with recovery testing now happening on a regular basis. Digital Services feels the current risk score should remain this is due to the continued targeting of backups by threat actors in malicious cyber attacks. [16/09/2025 14:21:37 Rachael Turner] Work continues to mature the Rubrik backup capability, with recovery testing now occurring on a regular basis. Risk score should remain as is due to the continued targeting of backups by threat actors in malicious cyber attacks. [10/06/2025 11:59:10 Rachael Turner] Development of the overall Digital Services BIA and BCP has progressed with both documents now under review by the Digital Services senior leadership. Rubrik continues to be progressed along with assignment of system tiers against all servers. [27/01/2025 09:44:28 Rachael	10	30/08/2024		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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5648	870	Physical or psychological harm	Daren Fradgley	Fradgley, Daren	Humber, Michael		25/04/2025	20	Corporate	Integration and Improvement		Trust-wide	The Trust is currently carrying a significant number of risks associated with the reliance on paper-based health records (covered by Datix risk ID 4731) and legacy stand-alone digital systems. There is currently an inability to deliver the required level of patient safety that is enabled by technology and innovation, via more robust and consistent clinician decision making and access to the right information in the right place at the right time. Without an integrated Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) the Trust risks not achieving the key benefits outlined in the EPR Full Business Case (FBC). There is clear evidence in the FBC that an EPR can deliver significant benefits to an organisation which may be unrealistic to deliver with (paper-based systems and) stand-alone digital health systems. These include: •Providing accurate, up-to-date, and	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.	[23/01/2026 13:18:02 Rachael Turner] While there are currently many mitigations and manual workarounds in place, that enables the organisation to operate and work more efficiently with paper based health records and stand-alone digital health systems, such as digital tracking of paper based case notes and use of back office systems. The Trust EPR is moving into delivery as is the EDMS which will digitise paper records, this project is currently in delivery and as planned to be completed 1st Qtr of 2026. [15/10/2025 10:05:17 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk score remains at an appropriate level. [13/10/2025 14:03:30 Rachael Turner] While there are currently many mitigations and manual workarounds in place, that enables the organisation to operate and work more efficiently with paper based health records and stand-alone digital health systems, such as digital tracking of paper based case notes	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?	Controls in place	How is the risk measured?	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk reduction plan	Progress update	Risk level (acceptable)	Initial expected completion date	Expected completion date	Review date
5519	739	Regulatory compliance	Daren Fradgley	Fradgley, Daren	Evans, Thomas		08/10/2024	16	Corporate	Integration and Improvement	Digital Services (ICT)	Trust-wide	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively	•Previously no defined lead for digital clinical safety established in the Trust. The CNIO has voluntarily taken the lead on Digital Clinical Safety (Trained CSO) within their substantive role, although clinical safety responsibility not outlined in job description / role and responsibilities. However, no resource for non-project/non funded DCSO work = risk •Digital Clinical Safety Officer (DCSO) post recruited into May 2024, as part of EPR programme (not revenue funded = risk). 1 further DCSO post has been included in the resource model for EPR implementation (>2025 funding) however, given the large volume of current in-flight Health IT System projects and legacy systems outside of EPR, this is not an adequate resource. •Digital Clinical Safety Policy now in the organisation (approved at DHG and Corp Gov – awaiting publication on the intranet) •Draft Clinical Risk Management System developed by new DCSO and awaiting Clinical Governance review before formal approval at DHG •Further development of required structures and governance standards to meet/comply with National standards and strengthen our position underway. •Digital Clinical Safety processes / awareness will require significant 'socialisation' to ensure they are effectively embedded. This will include clinical safety training for clinical / digital / operational colleagues	•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	04/12/2025	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Action 1. Develop and strengthen Digital Clinical Safety Function - will require funding for permanent staff including administrative resource to administer / manage the CRMS. 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	[08/12/2025 13:27:34 Rachael Turner] Review of risk - additional roles being recruited to, however these roles are all temporary roles, so only support activities during a defined period of time, the resource to manage the systems within the Group are not sufficient and additional concerns are being raised around locally owned systems in departments that are not compliant and have not followed appropriate processes. The risk of harm with these systems is significant. [15/10/2025 10:08:59 Rachael Turner] Risk discussed as part of RRC&C Deep Dive, risk score remains at an appropriate level. [30/09/2025 12:03:22 Rachael Turner] Risk reviewed, score remains. Clinical safety resource remains very limited and supporting a high number of programmes. [10/06/2025 12:19:29 Rachael Turner] Reviewed, meeting with Deputy Group Gov lead 23/05/2025 - for further review and return to risk confirm and challenge given new	12	08/10/2025		04/03/2026

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	*3 March 2026*
Agenda item number	*13.2*
Report title	*Group Board Assurance Framework*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance* • *Approval*
Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	*Considered through Board Committees*
Financial implications, if applicable	*N/A*
Action / decision required	*The board is asked to:* • *note progress with the development of the new group BAF;* • *note plans to further refine the group BAF over the coming months with continued input from lead executives and review and challenge from the relevant board committees;* • *agree the need for any additional action or assurance at this stage*

Assurance Rating Key:

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

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

Executive Summary

Background & Introduction

An effective BAF should guide the agenda setting for a board and its committees and, in turn, should be used as the framework for the board committees to report assurance and / or escalate gaps in assurance to the board in respect of delivery of the group's strategic aims & objectives.

In order to reflect the move to group and to provide a more high-level and concise view of the risks to the achievement of the group's strategic aims & objectives and, in turn, the controls, sources of assurance and any gaps, the LCHG Board had agreed in January 2025 to the introduction of a revised BAF format.

Work to further refine the new style BAF – including the addition of clear timescales and leads for agreed actions – and embed its use within the board and committee cycle will continue over the coming months. Each of the board committees, in turn, will continue to review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight with escalation, as required, to the Group Board.

Work is also underway as a priority to align the underpinning risks on the ULTH and LCHS risk registers to the relevant strategic risks within the BAF.

Summary of the Report

This report provides the second iteration of the BAF in the agreed new format.

BAF entries have been populated with reference to the previous LCHG BAF and with input from relevant executive directors.

The BAF has reviewed by all Committees during January and February and narrative updates provided. Following the development sessions held by the Quality and Integration Committees at the end of 2025, all feedback has now been captured within the BAF. A development session is planned for the People Committee in March to review the BAF in detail.

Group Board Action Required

The Group Board is asked to:

- note progress with the development of the new group BAF;
- note plans to further refine the BAF over the coming months (including the addition of clear timescales and leads for all agreed actions) with continued input from lead executives and review and challenge from the relevant board committees;
- agree the need for any additional actions or assurances at this stage.

Lincolnshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at February 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 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	Group Chief Operating Officer / Group Chief Integration Officer	Finance & Performance Committee	**15 (High)**	**10 (Moderate)**	**Amber**	**Green**
	1b (ii): Reduce waiting times for our patients **(Planned Care)**				**15 (High)**	**10 (Moderate)**	**Amber**	**Green**
	1c: Improve productivity and deliver financial sustainability	If we do not manage costs effectively, optimise productivity and deliver our cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unstainable services for patients	Group Chief Financial Officer	Finance & Performance Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	1d: Provide modern, clean and fit for purpose care settings	If we do not effectively **maintain our estates,** in line with mandatory & statutory requirements and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny	Group Director of Estates & Facilities	Finance & Performance Committee	**16 (High)**	**16 (High)**	**Amber**	**Amber**

People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through training, development and education	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Green**	**Green**
	2b: Empower our people to continuously improve and innovate	If we do not **empower our people to continuously improve and innovate** they will feel unable to perform their duties effectively and we will not deliver the required transformation in the quality, efficiency and effectiveness of our services resulting in a dissatisfied / disenfranchised workforce and poor clinical outcomes and patient experience	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2c: Nurture compassionate and diverse leadership	If we do no **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then our staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2d: Recognising our people through thanks and celebration	If we do not continue to **recognise our people through thanks and celebration** then we will be unable to attract and retain staff of the required caliber and experience resulting in services becoming unsustainable / fragile	Group Chief People Officer	People Committee	**6 (Low)**	**3 (Very Low)**	**Amber**	**Green**
Population: Better Health – Improve population health	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	If we do not **transform key clinical pathways**, rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving**	Group Chief Integration Officer	Integration Committee	**9 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

		population health resulting in less equitable access to services and poorer clinical outcomes						
	3c. Enhance our digital, research and innovation capability	If we do not **enhance our digital, research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)

Last Review Date:	February 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	

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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety priorities and KPIs agreed
2	Safety culture approach established~~, Patient Safety Partners appointed and human factors guidance & training in place.~~
	Patient Safety Partners appointed and human factors guidance & training in place.
3	~~Quality g~~Clinical Governance teams & structures~~, policies and processes (including robust processes to identify risks and issues)~~ in place and refined to reflect the move to group
4	Strong PSIRF process in place & learning from incidents processes well embedded. ~~Strong PSIRF process in place~~
5	Strong focus on maternity & neonatal safety reported through MNOG
6	Improvement plans in place to address identified risks e.g. management & use of medical devices, medicines safety, wound care management, effective practice & harm free care
7	Ward / service accreditation process in place
8	IPC team and governance framework in place across the group
9	Safeguarding team and governance framework in place across the group
10	Robust Patient Safety Alert System
11	Triangulation of learning
12	Governance structure under Quality Committee is in place and operating
13	Robust Care Group Governance arrangements
14	Datix system and process

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
	No gap
3	~~There are a significant number of policies across the group which are out of date~~ Ongoing vacancies due to current vacancy process in place.
4	~~'Just Culture principles not yet fully embedded across all areas of the group~~
5	~~Children & Young People Oversight Group to revert to reporting to Quality Committee for continued oversight of improvements within paediatric services~~
6	• ~~Medicines safety across the group remains a risk although oversight is improving~~ ~~There has been an increase in category 3 & 4 pressure ulcers in community services~~
7	Ward / service accreditation programme not fully embedded in community nd reporting
8	NHSE and other external reviews of the group's IPC arrangements have identified gaps
9	Low uptake of mandatory safeguarding training by operational teams
10	None identified
11	Learning approach not fully developed and embedded across the Group.
12	Groups beneath Committee not fully functioning
13	Gaps present during restructure
14	Currently running 2 Datix systems 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	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.
3	Aligned policy agreed on the development of policies, procedures & guidelines. Improvement trajectories to be agreed as a priority for bringing all out of date documents into compliance. Performance to be monitored through monthly PRMs with escalation to ELT / GLT as required	Group Director of Corporate Affairs	Deputy Trust Secretary	30 September 2025 (Agreement of Improvement Trajectory) 31 March 2026 (Improvement Performance)	Underway – paper being submitted to ELT on Thursday, 31 July 2025. Performance also being monitored from an assurance perspective through the Audit Committee
4	Weekly pressure ulcer assurance meetings being held with the community nursing teams with safeguarding support. Improvement Trajectory agreed	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 review and update in progress.~~reviewed and updated.~~
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.
7	Response to internal work and investigations and external visits of the group's infection prevention and control practice and interventions to be developed and implemented.	Group Chief Nurse	Deputy Director of Infection Prevention and Control	31 March 2026	Underway

8	Monthly monitoring and escalation for training noncompliance to Care Groups (CG leads / Safeguarding Operational groups and SVOG). Selective direct emails to noncompliant staff	Group Chief Nurse	Director of Safeguarding	31 March 2026	Ongoing
13	Implement Clinical Governance restructure	Group Chief Clinical Governance Officer	Deputy Chief Clinical Governance Officer		

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**
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025 -CLOSED**
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025** **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
3	Group level Medical Devices Group to be renamed to be representative of the LCH group	Group Chief Medical Officer	Deputy Medical Director	30 June 2025	Underway Update 08/10/2025 – Both Medical Devices Groups have now come together and has been renamed as the LCHG Medical Devices Safety Group. – Suggest CLOSED
4	Review of learning lessons mechanisms to be undertaken and a plan developed for a programme of learning lessons mechanisms across the group	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	31 December 2025 (plan)	Update 08/10/2025 – Launch of CG structure September included development of a three posts within the Compliance team that are dedicated to developing and supporting the triangulation of data and learning from all aspects of the Clinical Governance Directorate and ensure that there is a programme of learning in place across the Group. Update 13/11/2025 – Review of current process for PSII actions and learning taken place with a new process to be implemented from December. This will supplement the learning agenda across LCHG. 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.
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	403	20	Children's SLT treatment delays

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

9 (Moderate)

Last Review Date:	February 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	

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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and patient experience priorities and KPIs agreed
2	Patient Experience & Involvement Team in place
3	Established complaints & PALS teams
4	Group Complaints & PALS Policy agreed
5	Improvement Plans developed in response to national patient experience surveys
6	PLACE reviews completed and improvement plans developed
7	Systems for reporting for patient experience
8	Ward / service accreditation process in place

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	None identified~~Quality & safety and patient experience priorities and KPIs being refreshed~~
2	• Group approach to Patient Panels agreed and being implemented • ~~There are currently workforce gaps in the Patient Experience Team~~
3	None identified
4	None identified
5	Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans
6	PLACE improvement plans in development
7	Lack of capturing of diversity information
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~~	~~Agree patient experience metrics / KPIs that reflect the group priorities with oversight through the Patient Experience & Involvement Group to periodically assess that agreed actions are achieving the intended benefits and priorities~~	~~Group Chief Nurse~~	~~Head of Patient Experience~~	~~30 September 2025~~	~~Completed~~
2	Group approach to Patient Panels to be implemented from April 2025	Group Chief Nurse	Head of Patient Experience	1 April 2025	Completed
~~3~~5	Ensure action plans from national patient experience surveys are SMART and translated to local action and establish a robust process / protocols for disseminating data to frontline teams	Group Chief Nurse	Head of Patient Experience	31 December 2025	Completed
~~4~~6	Define and enforce timeframes for implementation of improvements identified during PLACE assessments	Group Chief Nurse	Head of Patient Experience	31 March 2026	Completed

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Patient Stores are heard at the Group Board
4	Patient Experience data is gathered and improvements tracked through the Patient Experience & Involvement Group
5	Delivery of patient experience KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
6	Internal & external audit, patient surveys, PLACE reviews etc. provide independent assurance on the quality of the patient experience

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	None identified
4	Triangulation of patient experience data with other sources of information e.g. complaints, PALS etc. requires strengthening
5	None identified
6	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025**
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet

					complete. Proposed revised deadline of 31 August 2025 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
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:	February 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	

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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Quality & safety and clinical effectiveness priorities and KPIs agreed
2	Established clinical audit team in place and clinical audit plan agreed
3	NICE Policy and process in place
4	Medical Examiner Service in operation
5	Mortality review process in place and learning from deaths process well established
6	Getting It Right First Time (GIRFT) Programs of work
7	~~Subgroup~~ 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	~~None identified~~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
~~1~~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~~2	GIRFT – The current GIRFT team structure is under review and a proposal is being developed to assess the team's capacity to implement effective governance	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 March 2026	Underway
~~3~~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.
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	31 March~~January~~ 2026	

			and Complaints		

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of clinical effectiveness and key risks by the Quality Committee and its reporting sub-group: the Clinical Effectiveness Group, with escalation to the Group Board as required
2	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group
4	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required
5	There is oversight of compliance with NICE guidance through the Clinical Effectiveness Group with escalation to the Quality Committee as required
6	Delivery of clinical effectiveness KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
7	Internal & external audit, external reviews and visits provide independent assurance
8	System Oversight

Gaps in Assurance	
1	Reporting sub-groups aligned.
2	IPR not yet aligned
3	None identified
4	'Outlier' status has been received for some of the National audit projects. As the Clinical Governance structure continues to develop, Clinical Audit Facilitators will work more closely with Care Groups to gain greater insight into audit processes and ensure the submission of high-quality, accurate data.
5	Overdue NICE Actions – As part of the structure, additional staff are being recruited to work more closely with Care Groups. This will strengthen oversight and support for the implementation and monitoring of NICE guidance, helping to reduce the number of overdue actions.
6	None identified
7	None identified
8	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Board and board committees have been aligned and executive governance structures agreed. Some final work to complete to align the committee reporting sub-groups. **Proposed revised deadline 31 August 2025 - CLOSED**
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025** **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
~~ULTH~~	~~4731~~	~~20~~	~~Reliance on paper medical records~~

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (i): Reduce waiting times for our patients **(Unplanned Care)**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm

Current Risk Score & Movement since last review:

15 (High)

Last Review Date:	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	

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	

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
3	Discharge task force being refreshed	Group Chief Operating Officer	Group Deputy Chief Nurse	30 April 2025	Completed
4	Escalation Policy & Full Capacity Protocol to be reviewed and aligned	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 July 2025	Underway **Proposed revised deadline of 30 November 2025**
9	Requirement remains for focus on community data to ensure clarity of service delivery and meeting patient outcomes.	Group Chief Integration Officer	Group Deputy Integration Officer	31 October 2025	Ongoing – data needs to be consistently available

Sources of Assurance (1st, 2nd and 3rd Line) (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
3	
4	
5	
6	
7	
8	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Newtons work will support improved discharge – with proposed daily target for each ward and specialty daily ED assurance meetings to discuss previous days and overnight activity and performance				

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	

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	

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	
5	
6	
7	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Diagnostic reporting tools in development	Group Chief Operating Officer	Deputy Group Chief Operating Officer	30 September 2025	Underway
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief Integration Officer	Associate Director of Performance & Information	30 June 2025	Group PMAF approved and aligned PRMs in place. The agreement of final metrics for 2025 / 26 and alignment of the IPR is not yet complete. **Proposed revised deadline of 31 August 2025** 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. 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
	Transformation of key services within envelope of money reported via Integration Committee	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 October 2025	~~Lymphodema trajectory agreed~~Complete – now an ongoing process
	Ongoing discussion with commissioners around commissioning support for Community Management Partnership Board	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 October 2025	~~Vulnerability of ICB moving to cluster~~ 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
~~ULTH~~	~~5447~~	~~20~~	~~Cancellation of elective lists due to theatre staffing~~

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1c: Improve productivity and deliver financial sustainability
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not manage costs effectively, optimise productivity and deliver our efficiency / cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unsustainable services for patients

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	February 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	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	

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	

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**
1	Harmonise the remaining financial policies across the group	Group Chief Financial Officer	Deputy Director of Finance – Financial Services	31 December 2025	Complete – approved in Audit Committee - October
2	Complete – approved in Audit Committee - October Completed – version is being updated by comms team to ensure consistency.	Group Chief Financial Officer	Deputy Director of Finance - Strategy	30 June 2025	Completed – First Finance roadshow training event held in February 2025. Budget holder refresher training held in February & March 2025 Ongoing training offer available within ESR
3	Agree the Group Finance Strategy	Group Chief Financial Officer	Deputy Director of Finance - Strategy	31 October 2025	Completed – version is being updated by comms team to ensure consistency.
4	Approve & implement the Group Performance Management & Accountability Framework (PMAF)	Group Chief Integration Officer	Deputy Director of Finance – Financial Management	30 June 2025	Group PMAF approved FPAM content reviewed with DMD lead, proposed finance meeting being reviewed and triangulation of other metrics concluded
5	Deliver the financial plan and maximise CIP opportunities with a focus on key high impact areas 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
6	Complete the work to harmonise the business case development, review and approval process	Group Chief Financial Officer	Deputy Director of Finance – Financial Services	31 July 2025	Complete – documentation standardised

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR)
3	Internal & external audit arrangements in place
4	Internal audit review of performance management and data quality within ULTH during 2024 / 25 provided 'reasonable assurance'
5	Assessment of 'grip and control' undertaken by external parties including through ICB and regulator challenge

Gaps in Assurance	
1	Reporting sub-groups not yet aligned
2	IPR not yet aligned
3	Internal audit arrangements have been aligned across the group but work remains ongoing to develop a single report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability
4	Internal audit review of overseas and contracts within ULTH provided 'limited assurance'
5	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and alignment of board, board committee and reporting sub-groups and executive governance structures being undertaken through the group development work programme (work stream 4)	Group Chair / Group Chief Executive	Group Director of Corporate Affairs	30 June 2025	Completed – clarity on reporting of efficiency (PITOF and PRMs) and activity (Planned and Unplanned Steering Groups), further work ongoing on other finance indicators
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025 / 26 is being undertaken as part of the group development work programme (work stream 2) 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** 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
3	Complete the work to develop a single internal audit report which reports at group and trust level recognising the need to maintain individual organisational sovereignty and accountability	Group Chief Financial Officer	Head of Internal Audit	31 August 2025	Internal audit reports updated

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description
ULTH	4664	20	Exceeding the agency cap – temporary staff
ULTH	5020	20	Reliance on agency / locum UEC medical staff
ULTH	5672	20	Risk of failure to deliver the CIP target in full for 2025/2026
~~ULTH~~	~~4839~~	~~20~~	~~Lack of pharmacy capacity for intravenous immunoglobulins~~

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:	February 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	5	4	16 (High)	Amber
Target	Mar-26	5	3	15 (High)	Amber

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Very High	Very High	Very High	Very High	Very High	Very High	Very High	Very High	High	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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Estates & Facilities Management (EFM) leadership & professional structures in place (including Authorising Engineers (AEs), Authorised Persons (APs) and Competent Persons (CPs). The Director of Estates & Facilities is the 'Designated Person' for EFM for the group and this is now a board role
2	EFM governance structure and safety groups in place reflecting Health Technical Memorandums (HTMs), Health & Safety legislation and other statutory requirements
3	Estates Strategy, Green Plans and EFM Transformation & Improvement Plans in place
4	EFM policies, processes, work plans and risk assessments in place covering HTMs, Health & Safety legislation and other statutory requirements. ~~Enhanced review of governance systems and structures within risk management and building CAFM (PPM's) has been completed.~~
5	Six-facet survey completed for ULTH in 2024: good level of understanding of the 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	~~There is currently a I~~Lack of EFM capacity due to the limited ~~EFM~~ 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	Continual auditing required
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 ~~– work underway to assess~~
6	The backlog maintenance programme for ULTH of £123m remains a significant risk. The lack of space and the need to decompress the acute site also remains a key area of focus
7	Inability to address critical infrastructure risks with limited capital

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Appoint to directorate critical / professional roles as a priority and in line with vacancy controls process	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	Ongoing	Completed
2	Recruit to the AE roles for LCHS during Q1 2025/26	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 June 2025	Completed
3	Transfer preventative and reactive maintenance for LCHS from NHSPS to the ULTH EFM team from 1 April 2025	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	1 April 2025	Completed
4	Undertake a planned preventative maintenance (PPM) and asset register review across the group ~~– to include the findings and response to the 2024 / 25 internal audit~~. Draft Report has been received and under-going accuracy and factual review.	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	1 April 2026	Audit Underway
5	Complete the work to bring together the Fire Safety, Health & Safety and Emergency Planning & Business Continuity Teams	Group Chief Estates & Facilities Officer	Group Chief Estates & Facilities Officer	30 April 2025	Completed
6	Complete the review of EFM governance structure and associated assurance processes	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 September 2025	Completed
7	Once the EFM risks in respect of LCHS are clear following the AE audits, service mapping exercise, PAM, review of leases and 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	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 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 & 20224/25 PAM evaluation submissions for LCHS show an improvement in compliance across the majority of domains although with good levels of compliance in the patient experience domain. The requirement for risk assessed, costed action plans for SAQs rated 'inadequate' or requiring 'moderate or minor improvements' was rated 'Inadequate' across all domains • Areas for focus from the PAM evaluation for both trusts, albeit to differing degrees, include Group alignment of policies, procedures & availability of documentation, risk assessment, maintenance, training & development and resilience, emergency & business continuity • ~~New PAM issued in draft Dec 2025, format has changed. These performance criteria have been removed and replaced with YES/NO method of response, coming away from the subjective style of rating. This methodology of assurance measurement features across all the self-assessment questions (SAQs).~~ • 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 provided 'limited assurance'
8	Asbestos, Water and Lift Reports received, awaiting further reports for ventilation pressure systems, med gas, confined space, LV.

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
3	Align the process for the completion and submission of the PAM by the 30 September deadline and strengthen the process for the delivery and oversight of agreed improvement actions through the year	Group Chief Estates & Facilities Officer	Deputy Directors of Estates & Facilities	30 September 2025	Complete

4	As part of the review of the board committee terms of reference and work plans, ensure there is greater clarity on the elements of the EFM agenda for which the Finance & Performance Committee has oversight and which come under the remit of the Integration Committee	Group Chief Estates & Facilities Officer	Group Director of Corporate Affairs	6 May 2025	Complete

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2a: Enable our people to fulfil their potential through training, development and education
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enable our people to fulfil their potential** through training, development and education then we will be unable to support delivery of new models of care resulting in reduced quality, increased risk of avoidable harm, less efficient services and the inability to attract and retain staff

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	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	

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	

	Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*	**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	People Systems Team are undertaking a review of ESR hierarchy structures to ensure reporting lines are validated / accurate to support leaders to access statutory / mandatory training and appraisal compliance, and support accurate recording of appraisals. Additionally, monitoring of workforce metrics / compliance rates through monthly performance meetings such as ~~FPAM and~~ PRM There is a plan in place to now send out ESR Hierarchy Reports twice per year to the Care Groups across the Group (planned to take place March in line with readiness for new financial year, and August (post Dr rotation) for mid-year review). Monthly reporting in place for Key Performance Indicators for the regular oversight of training, appraisal and workforce metrics to support compliance monitoring – this reports via a dashboard to Workforce Strategy Group and People Committee.	Group Chief People Officer	Head of Workforce Planning & Reporting / People Systems Manager	30 June 2025	Completed – embedded and added to controls and assurances
2	Monitoring uptake of leadership and development training through monthly performance meetings such as PRM, 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. ~~Review of FPAM Packs within the acute Trust (People Section) underway to bring in line with PRM format and report by exception. This will include updated training for Divisional Head of HR and Leadership Teams on how to access core People KPI Reports to maintain regular oversight~~ ~~ULTH has currently 'stood down' FPMA meetings so packs have not been created within 2025/26. It is not yet confirmed if these will be re-instated in year or not. Work had been done on the packs prior to cancellation of meetings and will continue once refreshed meeting are in place (as required).~~	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Completed – continues to be fully embedded **Proposed revised deadline of 31 March 2026**
6	People Promise work streams embedded within the Reward, Recognition & Engagement Manager role within the Education, Learning & Organisational Development Team to maintain oversight of People Promise themes	Group Chief People Officer	Education & Learning Manager	31 March 2026	Underway – on track
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 ~~FPAM and~~ PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard
6	Internal audit review of the people agenda provides independent assurance and / or escalation of risks. Internal audit review of mandatory training within ULTH undertaken during 2024 / 25 provided 'reasonable assurance'
7	National and regional benchmarking data considered through the People Committee and reporting sub-groups
8	External oversight and assurance in respect of people performance is undertaken through the Lincolnshire People Board/Workforce Committee
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
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 / Head of Workforce Planning & Reporting	31 July 2025	Completed – embedded and added to controls and assurances
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief People Officer	Group Deputy Director of People / Head of Workforce Planning & Reporting	30 June 2025	Completed – continues to be embedded
3	Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required)	Group Chief Medical Officer / Group Chief People Officer	Business Manager to the Group Chief Medical Officer / Head of Workforce Planning &	30 September 2025	Completed – continues to be embedded

			Reporting		
4	Regular report into Workforce Strategy Group and upward report into People Committee – to be reviewed and refreshed in line with 2025/26 objectives (as required)	Group Chief Nurse / Group Chief People Officer	Assistant Director of Nursing / Head of Workforce Planning & Reporting	30 September 2025	Completed – continues to be embedded
5	Review of standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Group Deputy Director of People / Head of Workforce Planning & Reporting	30 September 2025	Completed – continues to be embedded
6	Audit schedule to be requested and shared with key plan in place to manage audit cycles which impact People (close working between Corporate Governance and People Directorate required to deliver)	Group Chief People Officer	Head of Workforce Planning & Reporting	31 May 2025	Completed – continues to be embedded
7	All sub-groups to incorporate benchmarking (using as a minimum Model Hospital data) as regular agenda items in 2025/26	Group Chief People Officer	Group Deputy Director of People	30 June 2025	Completed – continues to be embedded
8	Develop and embed standard reporting mechanisms into Lincolnshire People Board / Workforce Committee	Group Chief People Officer	Deputy Group Chief People Officer	30 September 2025	Completed – continues to be embedded

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description
ULTH	4996	20	Consultant workforce capacity: Haematology

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2b: Empower our people to continuously improve and innovate
Strategic Risk: (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	

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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education, learning and development programmes and KPIs in place
2	Engagement 'Tube Map' – 'Better Together' Programme in place and ongoing including OD support
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle.
4	Improved Medical & Dental middle tier vacancy rate with a focus on stabilisation and succession planning through fully embedding a revised 'Plan for Every Post' process
5	Quality Improvement (QI) strategy/Quality Management System (QMS) being developed as a key enabler to support innovation/delivery of the group improvement/transformation agenda
6	Creating a culture of research and innovation recognised as a group priority
7	Workforce Planning

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Delivery of action plans and improvements at operational level needs to be incorporated into the Performance Management & Accountability and PRM process
2	Staff awareness at all levels of group strategy, values and approach to innovation and continuous improvement remains ongoing
3	2023 / 24 and 2024 / 25 job plans are still being finalised although significant improvements have been made
4	Division/Clinical Care Groups not yet fully owning the 'Plan for Every Post' process
5	Capacity of staff to engage with improvement agenda to be determined
6	Culture of research and innovation not yet embedded
7	Adverse to plan (M06) within Acute as a result of temporary staffing use, and approved substantive staff levels not included within plan

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms	Group Chief People Officer	Education & Learning Manager / Head of Workforce Planning & Reporting	30 September 2025	Completed & embedded and added to controls or assurances
2	Staff awareness at all levels of group strategy, values, behaviours and approach to innovation and continuous improvement remains ongoing and will form part of a rolling programme of regular communications and engagement in 2025 / 26	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
3 4	IPR metrics have been reviewed within People Directorate and shared, with alignment across LCHS and ULTH in line with Workforce Plans for 2025/26. People Committee Scorecard to be refreshed to ensure inclusion of current job planning and medical & dental middle tier rates for assurance purposes Plan for Every Post standardised framework in development to support ownership at Divisional Care Group level with clarity on roles and responsibilities and core enablers.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	31 May 2025	Completed & embedded and added to controls or assurances
7	Shadow Board in place since July 2025 to provide additional level of grip and control with a focus on temporary staff use, continuation of Vacancy Control Process to support risk based recruitment through a Quality Impact Assessment and weekly upward report to ELT, with forecasting included	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	31 March 2026	Underway – on track

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1 2	Upward Reporting: Pulse Survey and NHS Staff Survey results are reported to the Executive Leadership Team, People Committee and Group Board and action plans are monitored through the People Committee with escalation to the Group Board as required.
3 4	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Reporting on people KPIs to the People Committee and Group Board through the Integrated Performance Report (IPR)
5	Oversight of research & innovation has transferred to the Integration Committee

Gaps in Assurance	
1 2	Monitoring of action plan progress not fully embedded within sub-groups and relevant upward reporting, with priority focus being on the Divisional Clinical Care Groups monitored via PRM/~~FPAMs~~ so that leaders are accountable and undertaking their actions
3 4	Sub-Groups ensuring that agenda items and upward reports are in line with People Committee annual plan. IPR metrics currently being refreshed
5	Regular reporting to be established

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Completed & embedded and added to controls or assurances
2	Review and alignment of the PMAF and IPR and the development of metrics / KPIs for 2025/26 is being undertaken as part of the group development work programme (work stream 2)	Group Chief People Officer	Deputy Group Chief People Officer / Head	30 June 2025	Completed – continues to be embedded

			of Workforce Planning & Reporting		
3 4	People Directorate and Corporate Governance Directorate to work closely to develop a business as usual approach to sharing the People Committee work plan and ensuring that each sub-group is aware of its reporting objectives in year.	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 June 2025	Completed – continues to be embedded
5	Reporting requirements to be agreed as part of the refresh of the board committee terms of reference and work plans	Group Director of Corporate Affairs	Deputy Trust Secretary	30 June 2025	Completed – continues to be embedded

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description
ULTH	4997	20	Service configuration (Haematology)
ULTH	5093	20	Procurement service staffing levels (Pharmacy)
ULTH	4844	20	Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2c: Nurture compassionate and diverse leadership
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **nurture compassionate and diverse leadership** that is inclusive, promotes the group values and tackles unacceptable behaviours then out staff will not feel supported and valued resulting in poor staff satisfaction and well-being and lack of engagement

Current Risk Score & Movement since last review:

Moderate (9)

Last Review Date:	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	

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	

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	Underway – on track
2	LCHG Policy Group has commenced and is working collaboratively to review policies at pace. Policies have been prioritised to focus on contractual policies as the priority 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	Underway – on track
4	People Directorate Teams (Education, Learning & OD and People, Planning & Transformation) are working together to identify improved reporting within ~~FPAMs /~~ PRMS.	Group Chief People Officer	Education & Learning / OD & People & Transformation Teams	30 September 2025	Completed – continues to be embedded
5	Review of menopause service and review of funding options to be undertaken. 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	Group Chief People Officer	Deputy Group Chief People Officer / Head of Workforce Planning & Reporting	30 September 2025	Completed – continues to be embedded
3	In addition, to monitoring WRES and WDES actions through Equality, Diversity and Inclusion Group, this group will monitor incidents of sexual harassment, racism, ableism, homophobia and transphobia and other forms of discrimination, bullying, harassment and abuse, highlighting where additional actions need to be undertaken.	Group Chief People Officer	Deputy Director of People	31 March 2026	Underway – on track
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.	Group Chief People Officer	Education & Learning Managers	31 March 2026	Underway – on track
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 /	Deputy Group Chief People	30 June 2025	Completed – continues to be

		Group Director of Corporate Affairs	Officer / Head of Workforce Planning & Reporting		embedded

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 2: People

Strategic Aim:	People: Better Opportunities – Develop, empower and retain great people
Strategic Objective:	2d: Recognising our people through thanks and celebration
Strategic Risk: (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	

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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Reward and Recognition arrangements harmonised across the group including the development of a group Reward and Recognition Policy
2	Reward, Recognition and Engagement Manager in post to support ongoing work streams from 'People Promise' themes
3	ELT visibility and recognition of staff and teams through established communication and engagement channels
4	Annual staff awards ceremony held to recognise the contribution of individuals and teams
5	Robust review processes in place including appraisal, 1:1 meetings and feedback

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Policy approved but needs embedding
2	Role is in place within ULTH workforce but needs expanding to work across the group with an ability to utilise insights from this role to support wider reporting and identification of trends and development of action plans
3	None identified
4	None identified
5	Concept of group appraisals and appraisal lite process to be considered as part of review and alignment of HR policies

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Embed Group reward & Recognition Policy	Group Chief People Officer	Group Deputy Chief People Officer	31 March 2026	Completed – continues to be embedded
2	Review how the Reward, Recognition and Engagement Manager role aligns to wider LCHG work streams and how the role can bring insights to wider work streams, including reporting into ~~FPAM~~ 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	Group Chief People Officer	Group Head of Workforce Planning & Reporting	31 March 2026	Completed – continues to be embedded
2	Review the way in which Staff Survey action plans are monitored and reported through standardised monthly reporting and where required develop and embed refreshed business as usual reporting mechanisms. New approach introduced to both local and organisational staff survey action plan monitoring, via GLT and also Culture & Leadership Group reporting.	Group Chief People Officer	Associate Director of Culture & Wellbeing	31 March 2026	Underway – on track
3	To consider and develop an approach to how we identify, recognise and reward improving and exemplar pockets of culture across the Group – Just Culture; Compassionate Leadership; Equity & Inclusion, including sexual safety and other aspects of "United against Discrimination"	Group Chief People Officer	Associate Director of Culture & Wellbeing	31 March 2026	Underway – on track

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **transform key clinical pathways,** rationalise our estates and ensure patients receive their care in the most appropriate clinical setting we will not improve the quality of care and the patient experience

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	February 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	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	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	

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. December ASG pack includes 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 a 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	~~Alliance Steering Group currently only with internal group representation and lacks external membership. Movement of ICB to clusters has an impact on key roles and added uncertainty.~~
2	Pace of change and cultural mindset of working collaboratively needs to be embedded
3	Scale of delivery while implementing a blueprint of transformation for left shift
4	Sub-groups being established with partners supported by the diagnostic by Newton's (findings being reviewed and Phase 2 being scoped including potential delivery partner support)
5	Partnership Strategy 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 ~~to be reviewed and~~ 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	Director of Improvement and Integration / Deputy Chief Integration Officer	31 July 2025	~~Underway~~ 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	Director of Improvement and Integration / Deputy Chief Integration Officer	31 July 2025	**Complete and ongoing**
3	First PITOF meeting diarised for 12 May 2025 and to take place monthly	Group Chief Integration Officer	Director of Improvement and Integration	12 May 2025	Complete & ongoing
3.	Draft blueprint for specialty moves reviewed by ASG and Integration Committee – detailed plan developed ~~in development~~ 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..~~task force being established to oversee.~~	Group Chief Integration Officer	Director of Improvement and Integration	End Dec 2025	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 if fit for the future.	Group Chief Integration Officer	Deputy Director of Strategic Partnership	30 June 2025	Underway. Update to IC in December **Proposed revised timescale 31 March 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 are in the process of being developed as part of the annual planning submission in order to ensure the embedding of the approach within BAU.	Group Chief Integration Officer	Deputy Director of Strategic Partnership	December 2025	Underway – revised timescale in line with planning submission **Proposed revised timescale February 2026**

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of transformation work streams by the Integration Committee with escalation to the Group Board as required
2	External assurance will be provided through the Alliance Steering Group updates to Lincolnshire Leaders Group. Neighbourhood Board and partner provider boards
3	PITOF upward reports including reporting on delivery of key KPIs and milestones to the Integration Committee
4	IPR to support demonstration of a positive shift in key metrics such as improved LOS, improved staff and patient satisfaction, improved access to services
5	New Lincolnshire Neighborhood Health Board now established
6	Left Shift Programme Board updates/papers
7	
8	

Gaps in Assurance	
1	Consistent representation at ASG by key leads including corporate services
2	None identified ~~External partners not yet meeting as part of the Alliance Steering Group but the new Neighborhood Board will be a forum for system partner discussions.~~
3	Work streams, KPIs and timelines still being worked up with a digital dashboard being created, to be finalised in Q~~3~~4
4	None identified
5	No Partnership Agreement in place. Currently the 'managerial' and operational boundaries differ across LCHG, LCC, LPFT and PCNA
6	None identified
7	
8	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Integration Committee work plan and reporting sub-groups to be established including external partners where appropriate (with support from Newton's for INW)	Group Chief Integration Officer	Director of Improvement and Integration / Deputy Chief Integration Officer	31 May 2025	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	Director of Improvement and Integration / Deputy Chief Integration Officer	January 2026	~~Underway~~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	Director of Improvement and Integration / 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	Director of Improvement and Integration / Deputy Chief Integration Officer	Review March 2026	Underway
3	Strategy, improvement and redesign team working on pulling together programme plans for all the work streams to report through a central reporting mechanisms	Group Chief Integration Officer	Director of Improvement and Integration	31 May 2025	Complete

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	Director of Improvement and Integration	31 May 2025	Complete
5	Partnership Agreement to be agreed as soon as possible, and attempt to be made to map, 'managerial' and operational boundaries across LCHG, LCC, LPFT and PCNA to support neighbourhood health implementation. Working example on the NH Board January meeting agenda.	Group Chief Integration Officer	Director of Improvement and Integration	January 2026	Underway
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	Director of Improvement and Integration	Review March 2026	Underway

Related risks on Risk Register – ULTH

Trust	Datix ID	Score	Summary Risk Description
ULTH	5563	20	Neurology – Service sustainability
ULTH	5711	20	Risk to our transformation programme due to changes within the ICB

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3b: Move from prescription to prevention, through a population health management & health inequalities approach
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes

Current Risk Score & Movement since last review:

9 (Moderate)

Last Review Date:	February 2026
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	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	

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~~Little focus on prevention in system strategy/lack of investment in prevention~~
3	Embedding the data in decision making in local delivery plan.
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	Director of Integration and Improvement / Deputy Chief Integration Officer	31 July 2025	Complete
~~2~~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. -	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	Review March 2026	Underway
~~3~~5 / 6	Population Health data packs/intelligence embedded in the improvement methodology approach for left shift and wider transformation activities.	Group Chief Integration Officer	Director of Integration and Improvement / Deputy Chief Integration Officer	31 July 2025	Complete and ongoing

Sources of Assurance (1st, 2nd and 3rd Line) (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	
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	Ongoing discussion re: role of health providers in Resilient Communities e.g. stakeholder vs lead.
2	Strategy in development working with Chief Nurse/Head of Patient Experience, ICB Health Inequalities and Personalisation Teams with pilot approach in one of the left shift projects
3	Areas for improvement identified in TIAA audit – – incorporated and being delivered via HI action plan
4	
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 and corporate area plans required and are in development.	Group Chief Integration Officer	Associate Director of Partnership	31 July 2025	Underway
2	Neighbourhood Health Board Partnership Agreement in development that will define how partners will work together to deliver on neighbourhoods, planned and unplanned care and resilient communities (including role in prevention)	Group Chief Integration Officer	Director of Integration and Improvement	Review March 2026	Underway
3	Communications cascade to be developed (as one of the four Health Inequalities work streams) to increase awareness of the role of the Exec Lead for Health Inequalities and Personalization	Group Chief Integration Officer	Deputy Director of Strategic Partnerships/Deputy Director of Communications and Engagement	31 July 2025	Complete
2	New LCHG Strategy being deployed via Roadshow and in communications cascade	Group Chief Integration Officer	Director of Integration and Improvement	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:	November 2025
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Apr-25	4	2	8(Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	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	

Identified Controls *(What are we already doing to manage the risk?)*	
1	Digital Strategy for the group developed with a focus on digital transformation, integration & new ways of working
2	Digital systems across the group mapped and plan developed to align. 'Enabling Technology Programme in place to deliver improved technical infrastructure
3	Transition of LCHS and GPIT Digital services from AGEM to LCHG to enable and integrated digital approach.
4	EPR and EDMS programmes under way, both strategic enablers,
5	Disaster Recovery Plans in place. Cyber security & malware processes in place and tested
6	Digital Oversight Group in place to driver delivery of digital agenda
7	Key group focus on research and innovation including Artificial Intelligence (AI)
8	Process has begun for LCHS to become a teaching trust alongside ULTH

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	There is a need to enhance digital capability & skills through training
2	Insufficient capital / revenue to replace ageing technology
3	Alignment and change to operating model of LCHG Digital services to scale to the combined requirement, including transition.
4	Capacity within the digital team to deliver the digital transformation
5	Effectiveness of operational business continuity plans
6	None identified
7	LCHG Research & Innovation Strategy not yet developed - delays due to stakeholder availability
8	Application paused

Actions being taken to address gaps in controls *(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. 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

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of digital strategy, digital transformation and key risks by the Integration Committee
2	Digital Maturity Assessment completed
3	Digital Innovations Group established to assess and accelerate safe use of AI technologies
4	Oversight of AGEM IT service transition to LCHG via upward reporting to Integration Committee to manage risk, including agreement of structures.
5	Digital led business continuity exercise to identify improvement and learning, with departments providing assurance to Emergency Planning Group.

Gaps in Assurance	
1	None identified
2	None identified
3	None identified
4	Business as usual service assurance to be aligned to support service development and alignment to standards. Responsibility to move from AGEM to LCHG
5	Output of exercise upwardly reported and actions owned

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
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

Related risks On Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3d: Drive forward our improvement and efficiency agenda including sustainability and Green Plan
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable

Current Risk Score & Movement since last review:

12 (Moderate)

Last Review Date:	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	Apr-25	4	3	12 (Moderate)	Amber
Target	Mar-26	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

Risk Score	Apr-25	May-25	June-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	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	

	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**
4	Green Plans for LCHS and ULTH approved by Board to be published and shared with NHSE	Group Director of Estates & Facilities	Group Head of Sustainability	31 July 2025	**Complete** **Green Plans 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	
4	

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	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

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	*3 March 2025*
Agenda item number	*13.3*

Audit and Risk Committee Upward Report of the meeting held on 27 January 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:	3 March 2026
Report from:	Audit and Risk Committee
Report from meeting held on:	27 January 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 January 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) Compliance Report
e) Board Assurance Framework
f) Risk Report and External Risk Review
g) Policies and Procedures
h) Review of Annual Accounting Policies
i) Annual Accounts and Annual Report Plan and Timetable
j) Review of Committee Effectiveness

The External Audit provider confirmed that work had been initiated on the 2025/26 year end process. The report was a combined update across both Trusts noting that the audit opinions and final reports would be distinct. The Chief Finance Officer confirmed that there had also been a contract review meeting which had been positive.

The Committee received an internal report on the accounting treatments which would be applied for the 2025/26 process which were largely consistent with previous years.

The Internal Audit provider confirmed that five final audit reports had been published in respect of LCHS three with reasonable, one with substantial assurance and one none assurance report (cyber security maturity

assessment). ULTH also had five final reports issued all with reasonable assurance. The Committee considered how some of the findings from the reports would be triangulated with the work programmes of the assurance Committees and recognized that the risk profiles for the two organisations for some of the audit areas would differ.

The Committee noted that outstanding audit recommendations continued to be driven down and that the position was positive in terms of how this would feed the Head of Internal Audit Opinion at the year end. The Committee received assurance that these actions were the focus of discussions at the assurance Committees. The Committee received assurance that the audit plan would be completed in line with year end.

The Counter Fraud update into the Committee focused the communications being placed in the organization and the raising of awareness across the two organisations. The Committee were also advised of a pending prosecution which had now been given a date for court in February. The Committee would be kept updated. The Local Counter Fraud Specialist advised of training which had been offered around Failure to Prevent Fraud Legislation and a working group with senior staff from areas where the risks were likely to be carried. The Committee noted the assurance checklist in terms of the legislation and would receive a further position statement at the April meeting.

The Group Chief Finance Officer advised the Committee of the actions being taken in respect of contractual arrangements relating to Progress Housing and the financial implications. The Committee were advised of a new inventory management system improving the transparency and capture of stock.

The Committee received the output of the independent review of risk management processes and noted actions being taken and material improvements.

The Committee continued to offer challenge around the position in respect of overdue policies and procedures. The Committee were alert to the new challenges and the actions being taken. Committee members agreed that challenge in assurance Committee needed to be focused with lead executives to ensure that there was accountability. They would continue to monitor to ensure the position was turned around and noted the improved visibility.

The Committee supported a proposal to amend the Standing Financial Instructions for the Group in respect of delegated approval levels for contracts. The amendment reflected the scale of the Group and inflation levels and sought to reduce the level of non strategic contracts requiring Board approval.

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

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

a) The position in respect of overdue policies and procedures remained a focus for the Committee. The Group Chief Clinical Governance Officer offered an update on actions which had been taken with Care Groups since the Committee in October and ongoing actions to address the historic backlog of overdue documents.

4.0 Matters for reporting / escalation to the Group Board

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

a) The position with overdue policies and procedures remained a live escalation into the Board meeting

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

5.1 The committee considered the BAF and sought feedback and confirmed that the revised framework was supporting the work of the Committees with the assurances received. It was agreed that the new framework was working well whilst recognizing the continued development, two of the Board Committees had held workshop sessions to deep dive the detail in the BAF and this work was now being worked into the document. The annual internal audit review of the BAF and risk register were also underway.

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 January 2026

NHS
Lincolnshire Community and Hospitals NHS Group

Proposed Amendment to Standing Financial Instructions

Caring and building a healthier future for all

Meeting	*Public Board*
Date of meeting	*3rd March 2026*
Agenda item number	
Report title	*Proposed Amendment to Standing Financial Instructions*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Decision
Accountable Director	*Paul Antunes-Goncalves, Group Chief Finance Officer*
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	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *Consider and approve the recommendation from Audit Committee to amend approval levels for contract awards within the Group SFI's*

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

The HFMA NHS Audit Committee Handbook states that the first duty of the Audit Committee is to review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities, that supports the achievement of the organisations' objectives.

The way that an NHS organisation is directed and controlled in terms of its corporate governance is set out through its suite of governing documents. These should be reviewed regularly and updated to ensure that they represent current best practice and national guidance and are relevant (for example that delegation limits and authorisation levels remain appropriate).

The Audit Committee are expected to undertake the detailed scrutiny of such changes before formal adoption by the Board.

Following Executive discussion Audit Committee were asked to consider the revision of the Trust Standing Financial Instructions to increase the Group Board approval level for contract award reports for both organisations to those contracts above £5m in value. The current level is £1m. With the scale of the Group and inflation this has resulted in an increasing number of none strategic contracts needing to seek Board approval. The Group Audit Committee supported this change and have recommended it for approval by Board.

Existing approval levels in SFI's are shown below

	Total Contract Award Value				
	<£25,000	<£100,000	<£250,000	<£1m	£1m+
Care Group Lead	X	X	X	X	X
Head of Category	X	X	X	X	X
Divisional Head of Finance	X	X	X	X	X
Deputy Director of Procurement		X	X	X	X
Group Chief Finance Officer			X	X	X
Group Chief Executive				X	X
Finance and Performance Committee					X
Trust Board					X

Proposed approval levels would move to the table below

	Total Contract Award Value					
	<£25,000	<£100,000	<£250,000	<£1m	<£5m	£5m+
Care Group Lead	X	X	X	X	X	X
Head of Category	X	X	X	X	X	X
Divisional Head of Finance	X	X	X	X	X	X
Deputy Director of Procurement		X	X	X	X	X
Group Chief Finance Officer			X	X	X	X
Group Chief Executive				X	X	X
Finance and Performance Committee					X	X
Trust Board						X

In the last year the Board have received 33 Contract Award Reports which were over £1m in value. If the proposed revised approval level was implemented this would have reduced to 8 Contract

Lincolnshire Community and Hospitals NHS Group
Board Work Programme 2025/26

Agenda Item	Lead	Person Responsible	Committee Oversight	Mar	May	Jul	Sep	Nov	Jan	Mar	Purpose of Report	Action
Business Items												
Public Questions	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X		
Ward Accreditation	Group Chief Nurse		N/A	X	X	X	X	X	X	X		Assurance
Declarations of Interest	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To note any conflicts of interest on specific agenda items or any changes to Directors' Interests	Assurance
Annual Declaration of Board Interests	Group Chair	Group Director of Corporate Affairs	N/A		X						To review and note any changes to the Register of Directors' Interests	Assurance
Fit and Proper Person Annual Declaration	Group Chair	Group Director of Corporate Affairs	Audit & Risk Committee			X (def. from May)					To receive assurance that all board members remain compliant with the Fit & Proper Person requirements	Assurance
Minutes of the previous meeting	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained	Approval
Matters arising from the previous meeting/action log	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X	To ensure all agreed board actions are completed	Assurance
Group Chief Executive Report to the Board	Group Chief Executive	Executive Business Manager	N/A	X	X	X	X	X	X	X	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	
Group Workstreams Progress Briefing	Group Chief Executive		N/A	X	X	X	X	X	X	X	To receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services	
Celebrating Group Success	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To hear from Clinical Teams and give clinical teams access to the Board	
Patient/staff Story	Group Chief Nurse	Associate Director of Communications and Engagement	N/A	X	X	X	X	X	X	X	To receive direct feedback on the experience of both patients and staff	
Patients												
Strategic Aim 1 - High quality, timely care in the right place												
Assurance and Risk Report from the Quality Committee	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Quality Committee Annual Report	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Quality Committee ToR and Work Programme	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee		X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Safeguarding Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Infection Prevention and Control Annual Report	Group Chief Nurse	Deputy Director of Infection Prevention and Control	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Complaints Annual Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Patient Experience Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee				X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Assurance and Risk Report from the Finance Committee	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Finance Committee Annual Report	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Finance Committee ToR and Work Programme	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Financial Plan	Group Chief Finance Officer		Finance Committee								To approve the Financial Plan	Approval
Capital Plan	Group Chief Finance Officer		Finance Committee								To approve the Capital Plan	Approval
Contract Award Reports	Group Chief Finance Officer	Deputy Director of Procurement	Finance Committee	X	X	X	X	X	X	X	To approve relevant Contract Awards in accordance with the Trusts' Schemes of Delegation	Approval
Emergency Preparedness Annual Report and EPRR Core Standards	Group Chief Estates and Facilities Officer	Emergency Planning and Business Continuity Manager	Finance Committee			X					To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Assurance
People												
Strategic Aim 2 - Attract and retain talent, build a strong culture												
Assurance and Risk Report from the People Committee	Chair of People Committee	Deputy Trust Secretary	People Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
People Committee Annual Report	Chair of People Committee	Deputy Trust Secretary	People Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
People Committee ToR and Work Programme	Chair of People Committee	Deputy Trust Secretary	People Committee					X			To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Gender Pay Gap Report	Group Chief People Officer	Director of People	People Committee	X						X	To receive the Gender Pay Gap Report	Assurance
Ward Establishment Review	Group Chief Nurse	Deputy Director of Nursing and Midwifery	People Committee				X (def. from May)			X (deferred)	To approve the outcome of the review of safe staffing and any recommended changes to the establishment	Approval
Responsible Officer Revalidation Report	Group Chief Medical Director	Deputy Medical Director	People Committee				X					
National Staff Survey Results	Group Chief People Officer	Director of People	People Committee		X					X	To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements	Assurance
FTSU Annual Report	Group Director of Corporate Affairs	FTSU Guardians	People Committee					X			To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Equality Delivery System Report	Group Chief People Officer	Director of People	People Committee		X					X	To approve the annual EDS submission	Approval
Workforce Race Equality Standard (WRES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee				X				To approve the annual WDES submission	Approval
Workforce Disability Equality Standard (WDES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee				X				To approve the annual WDES submission	Approval
Population Health												
Strategic Aim 3 - Adapting to neighbourhood health needs												
Assurance and Risk Report from the Integration Committee	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee	X	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Integration Committee Annual Report	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee		X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Integration Committee ToR and Work Programme	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee		X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Risk and Assurance												
Integrated Performance Report	Group Chief Integration Officer	Associate Director of Performance and Information	Finance Committee	X	X	X	X	X	X	X	To brief the boards on key performance metrics & priorities, risks to delivery & mitigations	Assurance
Group Risk Management Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Audit & Risk Committee	X	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Board Assurance Framework	Group Director of Corporate Affairs	Deputy Trust Secretary	Audit & Risk Committee	X	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Strategic Objectives	Group Chief Integration Officer	Director of Strategy and Planning		X						X	To approve the Group Vision, Strategy & Objectives	Approval
Assurance and Risk Report from the Audit Committee	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X	X		X	X		X	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Audit Committee Annual Report	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee					X			To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Audit Committee ToR and Work Programme	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X						X	To approve the changes to board committee terms of reference and work plans following annual review.	Approval
NHS Provider Licence Self Certification	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee		X						To agree the annual Trust Board self certification of compliance with the NHS Provider Licence	Approval
Year End Accounts and Annual Report	Chair of Audit Committee	Group Chief Finance Officer/ Group Director of Corporate Affairs	Audit & Risk Committee			X					To approve and adopt the Annual Report & Accounts	Approval
End of meeting												
Board Work Programme	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	X	To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements	Assurance
Any other notified items of urgent business	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	X		