Bundle LCHG Board Meeting in Public Session 3 November 2026

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

1 Introduction, Welcome and Chair's Opening Remarks

2 Public Questions
Item 2 Public Board Questions

2.1 Ward Accreditation - Greetwell Ward

2.2 Patient/Staff Story

3 Apologies for Absence

4 Declarations of Interest

5 Minutes of the meeting held on 1 September 2026
Item 5 DRAFT Public Board Minutes Sept 26

5.1 Matters arising from the previous meeting/action log

6 Group Chief Executive's Report to the Board
Item 6 Group CEO update Public Board -November 2026

6.1 Single Organisation Update
Item 6.1 Single Organisation Oversight Group Upward Report November 2026
Item 6.1 Appendix 1 Single Organisation Programme Plan as at 5 October 2026 Final

7 BREAK

8 Strategic Aim 1 - Patients

8.1 Risk and Assurance Report from the Quality Committee
Item 8.1 Quality Committee Assurance Upward Report - September 2026v1
Item 8.1 Quality Committee Assurance Upward Report - October 2026 v 3
Item 8.1 Oct 1 Appendix 3.3-10PP Assurance Template v1.0 020926
Item 8.1 Oct 2. Appendix 3.1- CNST MIS Year 8 mid-point review V1.1 0192026
Item 8.1 Oct 5. Appendix 5.0- Integrated workforce report V1.0 17082026 1
Item 8.1 Oct 6. Appendix A- CNST MIS Year 8 SAB training risk v1.0 11102026
Item 8.1 Oct 7. Appendix 6.0 - Learning and Actions Thematic Report Q1 2026
Item 8.1 Oct 11. Appendix 6.4- PMRT Q1 report - None identifiable data
Item 8.1 Oct 12. Appendix 6.5- Claims Scorecard Q1 '26-'27
Item 8.1 Oct 14. Appendix 3.2- MCB implementation tool ULTH V1.4 28092026

8.2 Thirlwall Inquiry Report and Recommendations
Item 8.2 Board Report - Thirlwall

8.3 Finance Briefing
Item 8.3 Board - Finance Briefing M6 2627

8.4 Assurance and Risk Report from the Finance and Performance Committee

Item 8.4 Finance Committee Assurance Upward Report September 2026 v 5
Item 8.4 Finance Committee Assurance Upward Report October 2026v1

8.5 Estates Operational Delivery Plan

Item 8.5 Covering Paper for Trust Board_Estates Operational Delivery Plan 2nd November 2026
Item 8.5 Appendix 1 LCHG Estate Long Term Delivery Plan 2026 2036.docx final
Item 8.5 - Appendix A LCHG Estate Strategy_Technical Appendix v8b PDF
Item 8.5 - Appendix B Site List Overview
Item 8.5 - Appendix C LCHGES-GDA-00-XX-RP-A-9001_P05_Development Control Plan
Item 8.5 - Appendix D RWD_Estates&Facilities_Summary_20261007_101408
Item 8.5 - Appendix E Structure-chart

9 Strategic Aim 2 - People

9.1 Assurance and Risk Report from the People Committee

Item 9.1 People Committee Assurance Upward Report September 2026 v 2
Item 9.1 Appendix 1 (Sept) FTSU Annual Report 25-26
Item 9.1 Appendix 2 (Sept) PC Work Well Plan - People Committee
Item 9.1 0. People Committee Assurance Upward Report October 2026 v 3
Item 9.1 Appendix 1 Oct. Communications and engagement dashboard 2026-09
Item 9.1 Appendix 2 Oct People Committee - Terms of Reference 26-27 (Draft) v 3
Item 9.1 Appendix 3 (Sept) Communications and engagement dashboard 2026-08

9.2 Unauthorised, inappropriate and unjustifiable access to confidential patient information

Item 9.2 Board Paper_IG cases 1026 Final

10 Strategic Aim 3 - Population

10.1 Assurance and Risk Report from the Integration Committee

Item 10.1 Integration Committee Assurance Upward Report September 2026 v 2
Item 10.1 Appendix 1 (Sept) Integration Committee ToR 2026-27 v 3
Item 10.1 Integration Committee Assurance Upward Report October 2026

10.2 Electronic Patient Record Update

Item 10.2 EPR Programme Report for Trust Board Nov 26Rev3

11 Integrated Performance Report

Item 11 Front Sheet - Group Board Dashboard October (September Data)
Item 11 Appendix 1 Group Board October 2026

12 Risk and Assurance

12.1 Group Risk Management Report

Item 12.1 Group Board - LCHG Risk Report Nov 2026
Item 12.1 Appendix A - LCHS Group Board Risks rated High or Very High - November 2026.
Item 12.1 Appendix B - ULTH Group Board Risks rated High or Very High - November 2026.
Item 12.1 Appendix C - Risk Appetite

12.2 Board Assurance Framework

Item 12.2 BAF Group Board Front Sheet November 2026

Item 12.2 LCHG Group BAF for Group Board October 2026

12.3 Risk and Assurance Report from the Audit Committee

Item 12.3 Audit Committee Upward Report Oct 2026

13 Board Forward Planner

Item 13 Board Work Programme 2026-27

14 Any Other Notified Items of Urgent Business

15 The next meeting will be held on Tuesday 5th January 2027

Public Board Questions – November 2026

Q1 from Nikki Applewhite

My question to the Board concerns its responsibility for ensuring that patients' concerns lead to lasting change - What specific, measurable action will the Board take to address recurring concerns about care and communication in Lincoln County Hospital's A&E department, with named executive responsibility, deadlines and public reporting of progress?

Group Chief Nurse to respond.

Q2 from David Burlington

Following the rollout of the centralised Patient Services Hub across United Lincolnshire Teaching Hospitals, patients and clinicians have highlighted severe operational bottlenecks. These include a documented backlog of **25,000 to 35,000 un-typed outpatient clinic letters**, excessively long phone queues, and frontline clinical staff having to divert from patient care to act as administrative investigators. Could the Board please address the following three points:

1. What specific factors caused the severe administrative backlog and the breakdown in telephone response times following the consolidation of the legacy systems?
2. Given that this transformation programme impacted **650 employees** and condensed **15 legacy booking systems and 40 separate mailboxes**, why were these capacity shortfalls and transitional risks not accurately predicted or mitigated during the initial planning, business case development, and staff consultation phases?
3. What is the precise timeline, resource allocation, and key performance metric framework of the active **recovery plan** to clear the letter backlog, stabilise call-waiting times, and ensure patient safety is protected against missed clinical follow-ups or delayed referrals?

Group Chief Operating Officer to respond.

Q3 from Vi King

Please can I ask why patients relatives are being informed that the patient is ready for discharge. When arriving at the hospital they are having to wait for many hours for the patients medication to take out (TTO), after they have been deemed medically fit for discharge.

With patients having to wait for a bed in A/E or from the wards this needs to be looked at to create a much better patient flow.

Also please can you tell when a patient has been moved to the discharge lounge how long they should be there? Some patients are having to wait several hours.

Group Chief Operating Officer to respond.

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

Minutes of the Joint Public Board Meeting

Held on 1 September 2026

Via MS Teams Live Stream

Present

Voting Members:
Mrs Rebecca Brown, Group Chair
Mr Jim Connolly, Deputy Chair/Non-Executive Director
Mr Neil Herbert, Non-Executive Director
Ms Dani Cecchini, Non-Executive Director
Professor Jamie Read, Non-Executive Director (ULTH)

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

Non-Voting Members:
Ms Caroline Landon, Group Chief Operating Officer
Mrs Kathryn Helley, Group Chief Clinical Governance Officer
Mr Mike Parkhill, Group Estates and Facilities Officer
Miss Claire Low, Group Chief People Officer
Mrs Jayne Warner, Group Director of Corporate Affairs
Mrs Sarah Booth, Group Communications and Engagement Officer
Mr John Underwood, Associate Non-Executive Director
Mrs Linda Jackson, Associate Non-Executive Director
Mr Paul Marsden, Associate Non-Executive Director

In attendance:
Mrs Karen Willey, Deputy Trust Board Secretary, ULTH
Mrs Rachel Lane, Board Administration, LCHS (minutes)
Christine Jenkinson, Community Team Lead, LCHS (Item 3)

Apologies:
Professor Ciro Rinaldi, Deputy Group Chief Medical Officer
Mrs Vicki Wells, Non-Executive Director
Mr Ian Orrell, Associate Non-Executive Director

708/26	**Item 1 Introduction** The Group Chair welcomed Board members and members of the public, staff or interested parties who had joined the live stream.
709/26	The Group Chair thanked staff, volunteers, carers and partners for their continued commitment to providing high quality care for the population of Lincolnshire.

710/26	The Group Chair reflected on the continued national focus on strengthening community based services, improving maternity care, progressing social care reform and delivering the 10 year Plan, all of which aligned with the Group's strategic direction and priorities.
711/26	The Group Chair offered that a significant milestone had been reached for the Group on 12 August 2026, with the announcement of the intention to merge into a single organisation and it was recognised that this was an important step in building on the achievements of the Group model; enabling further and faster transformation of services and the delivery of the Group strategy.
712/26	Extensive engagement with staff, patients, residents and stakeholders would take place over the coming months to inform the development of proposals and ensure the organisation's future direction reflected stakeholder views.
713/26	Progress on the development of the Patient Services Hub (PSH) had been made over recent weeks, and Board members acknowledged the significant amount of work invested in the development of the PSH and positive progress to improve communication and access for patients and families. The Group Chair offered that further work was required to realise the full benefits, and regular monitoring would remain in place to ensure the programme delivered its expected outcomes.
714/26	**Item 2 Public Questions** **Question 1 Received from Vi King** Please can I ask why patients' face to face appointments in general surgery are being cancelled at Grantham and no reason given. Also, please can I ask about the lack of secretaries, as patients letters are not being typed up in a timely manner so if the letter has not been typed, when patients go to their follow up appointments, doctors have no information. Also, there is a delay with patient's letter's being sent to the GP to that so they can get new prescriptions from their GP.
715/26	The Group Chief Operating Officer explained that 26 clinics had been cancelled at Grantham Hospital during August 2026, 15 due to unavoidable clinician absence, five were cancelled due to annual leave and six had been utilised to accommodate post multidisciplinary team suspected cancer pathway patients. The Group Chief Operating Officer offered that staff had worked hard to meet current demand across the board during August, as the cancer pathway had increased with over 100 new patients and 80 follow up appointments. Staff were working hard to manage capacity at Grantham Hospital and reduce unnecessary follow ups and phoning Did Not Attends and would continue to ensure they were doing all they could to ensure appointments at Grantham were being made and honoured.
716/26	With regards to patient letters, the Group Chief Clinical Governance Officer explained that with the introduction of the PSH one of the key enablers had been to improve the service offered to patients in receiving appointments and letters. As part of the PSH process staff had been transferred into new roles which had left delays in some areas. Most letters related to administrative changes informing GPs that patients had been discharged from services. The Group Chief Clinical Governance Officer

	explained that the Group was assured that through processes and feedback from GPs and the Group Chief Medical Officer's office, that issues being shared with GPs were not things that needed to be acted upon, as that would be undertaken during clinic appointments whilst patients remained on site.
717/26	The Group Chief Clinical Governance Officer encouraged patients with queries to contact the PSH or the Patient Advice and Liaison Service (PALS) who could help navigate through any issues.
718/26	**Question 2 Received from Jody Clark** I wanted to submit a question regarding respiratory consultant issues across the trust. With Grantham Hospital being at risk under these shortages, can you please assure me that anyone presenting with respiratory issues at the Urgent Treatment Centre, will be able to receive treatment? It is a concern as EMAS cannot provide advanced respiratory therapy and it puts Grantham Patients at significant risk
719/26	The Group Chief Operating Officer responded providing assurance that the respiratory service was currently available at Grantham Hospital and would continue to be maintained. Respiratory consultant cover was provided at Grantham Hospital as part of the Harrowby Ward establishment, with consultants responding to referrals from the Urgent Treatment Centre (UTC) within their job plans during normal working hours. Out of hours, clinical teams were able to contact the relevant respiratory consultant for specialist advice and guidance. Staff were also actively encouraged to seek support from either consultant as appropriate.
718/26	The Group Chief Operating Officer explained that patients requiring specialist respiratory assessment or treatment could be transferred to Lincoln County Hospital or Pilgrim Hospital, Boston and those patients requiring onward admission were identified through the triage process, with transfer arrangements enacted in conjunction with East Midlands Ambulance Service (EMAS) where necessary.
719/26	The Group Chair offered thanks to Mrs King and Ms Clark for submitting their questions.
720/26	**Item 3 Patient/Staff Story** The Group Chair welcomed Community Team Leader, Christine Jenkinson to the meeting who presented the Patient Story, which highlighted exceptional collaborative care across community, hospital and partner organisations.
721/26	The Community Team Leader informed Board members that incomplete information sharing during discharge of a palliative care patient had caused delays for community teams. The patient's needs had been met, readmission was avoided and teams worked together to support the patient's wish to spend meaningful time with his family, including a trip to Disneyland Paris.
722/26	Multi-disciplinary working had enabled teams to deliver a highly personalised outcome for the patient and his family, and the significant impact of the care provided, creating lasting and meaningful experiences for the family.

723/26	The Community Team Leader reflected that it had been a privilege to be able to facilitate the patient's wishes and reflected on the personal and professional rewards of delivering truly person centred care.
724/26	The Group Chief Executive offered that this had been a powerful example of the benefits of integrated working across organisations, which had enabled the delivery of the right care, in the right place at the right time. This had also demonstrated the value of neighbourhood and multidisciplinary team approaches, as well as effective partnership working with external agencies.
725/26	The Group Chief Integration Officer expressed his gratitude to the patient and family for sharing their experiences. He added that this story served as a reminder of the impact of staff efforts and the importance of maintaining patients and families at the centre of decision making.
726/26	The Group Chair thanked all teams involved for their dedication, professionalism and compassion and requested that the appreciation of the Board be passed on to all staff involved and the family.
727/26	The Group Chair thanked the Community Team Leader for the presentation.
728/26	**Item 4 Apologies for Absence** Apologies for absence had been received from Professor Ciro Rinaldi, Group Chief Medical Officer, Mrs Vicki Wells Non-Executive Director and Mr Ian Orrell, Associate Non-Executive Director.
729/26	**Item 5 Declarations of Interest** No additional declarations of interest were made. The Board: • **Accepted the Declarations of Interest Register**
730/26	**Item 6 Minutes of the meetings held on 5 May 2026** The minutes of the meeting held on Tuesday 7 July 2026 were approved as an accurate record.
731/26	**Item 6.1 Matters Arising from the previous meeting/log** The Board acknowledged that there were no open actions on the action log.
732/26	**Item 7 Group Chief Executive's Report to the Board** The Group Chief Executive acknowledged that services across Lincolnshire had remained extremely busy during the summer, particularly during times of heatwave with increased demand on Urgent and Emergency Care (UEC) with activity increased

	by 2% - 3%. Despite these issues, the Group continued to provide safe, compassionate care and the opportunity was taken to thank colleagues for that.
733/26	The Group Chief Executive presented the report to the Board which offered key developments for July and August 2026.
734/26	In July the Group Chief Executive officially opened the new Endoscopy Unit at Lincoln County Hospital, alongside Group Chair Rebecca Brown, the Mayor of Lincoln, Councillor Clare Smalley, the City Sheriff, Darryl Smalley, the Deputy Mayor for Greater Lincolnshire, Councillor Ingrid Sheard, and the Deputy Lieutenant of Lincolnshire, Ursula Lidbetter. The new £26.5 million state-of-the-art unit provided a modern, accessible facility for patients and significantly enhanced the working environment for staff. The development would increase diagnostic capacity, support earlier diagnosis and treatment, and further improve the patient experience through enhanced privacy, comfort and dignity. The unit began treating patients on 3 August 2026.
735/26	Good progress continued to be made on delivery of the Electronic Patient Record (EPR) within United Lincolnshire Teaching Hospitals NHS Trust (ULTH). Training for colleagues was being undertaken on use of the new system, alongside practical training on using mobile technology at the patient bedside. The new system would be live on all inpatient wards, both adult and children, as well as Emergency Departments from Tuesday 13 October 2026.
736/26	The Group Chief Executive explained that the Group had announced its intention to merge on 12 August 2026. A single organisation would reduce duplication and deliver improved care for the people of Lincolnshire, and a strategic case had been approved by NHS England, which was progressing to the development of a full business case.
737/26	Within the PSH improvements had been seen in several areas, however it was recognised that there was now more to do and solutions were being co-designed to deliver further improvements for patients.
738/26	There had been several areas of national focus improvements during July and August 2026 including in maternity services, enhanced governance on death care and mortuary services, Information Governance requirements and NHS leadership and management frameworks; all of which aligned with the Group’s commitment to quality, safety and continuous improvement.
739/26	The Group had recently implemented the introduction of Forget-Me-Not wristbands for patients living with dementia, memory loss or confusion who access Urgent and Emergency Care services across our Acute and Community Hospitals. The wristbands were being offered during initial triage and assessment process where a patient had a formal diagnosis of dementia, or where there were concerns regarding memory loss or confusion. These served as a clear visual prompt for all staff involved in a patient's care, helping to improve communication, enhance the patient experience and support the delivery of more personalised, compassionate care.

740/26	The Group Chief Executive offered that this year's Staff Awards had attracted 950 nominations which demonstrated the exceptional talent, commitment and compassion which existed across the Group and thanked colleagues across all services for supporting patients, improving services and driving innovation. All of which made a difference and moving into the autumn the Group Chief Executive offered that the focus would continue to be on the delivery of high quality, safe care and shaping a stronger future in Lincolnshire for health services.
741/26	The Group Chair thanked the Group Chief Executive for the report and acknowledged that this was full of innovation and change taking place within the Group, with much to be proud of moving forward. The Board: • **Received the report and noted the significant assurance provided**
742/26	**Item 7.1 Single Organisation Update** The Group Chair offered that there had now been formal agreement to move forward to a Full Business Case for a single organisation.
743/26	The Group Chief Executive explained that updates would continue to be offered within the Public Board meetings moving forward towards the ambition to create a single organisation for Lincolnshire Community and Hospital Services, with the intention to merge Lincolnshire Community Health Services NHS Trust and United Lincolnshire Teaching Hospitals NHS Trust.
744/26	The Group Chief Executive advised that members of the Group were working closely with colleagues from NHS England and other partners to develop a business case to bring the organisations together. The rationale remained clear to provide an opportunity to improve services, strengthen resilience of services and make the best possible use of skills. There were risks associated, including ensuring sufficient leadership and programme capacity to deliver this alongside day to day pressures and demonstrated clear and measurable benefits whilst going through assurance processes.
745/26	Mitigations were in place to manage and continue to strengthen leadership and governance arrangements, and time would be spent engaging with staff and further deliver the benefits framework. A clinically led and patient focussed programme of work would be undertaken, listening to and responding to feedback on planning and decision making and the Group Chief Executive offered that she was encouraged by the progress already made across both organisations.
746/26	The Group Chief Executive explained that the intention was to create a stronger more integrated organisation which was able to meet the future needs of the population of Lincolnshire.
747/26	Mrs Jackson recognised the complexity of the work involved in the merger programme, workstreams, actions and accountability arrangements in place. It was acknowledged that due diligence would be shared through the appropriate governance processes as the work developed, however assurance was sought as to

	how this work would be undertaken effectively alongside existing responsibilities and whether there was sufficient capacity to deliver key priorities over the coming months.
748/26	The Group Chief Executive responded that the due diligence elements would be discussed during today's Private Board meeting, however with regards to additional support Board members were advised that there was external support working on the this and Executives had worked through the support which could be offered within their own teams and budgets. A schematic was being developed across each workstream to review the further support required for each portfolio.
749/26	From a people perspective, the Group Chief People Officer explained that dedicated resource had been identified from existing budget to support that workstream.
750/26	Mr Connolly offered that following a recent visit to Louth Hospital, staff members were in support of the merger however there were some concerns expressed with regards to day-to-day operational issues and asked if themes were being collated.
751/26	The Group Chief Executive offered that several staff briefings had been held, and all Executives and Non-Executives had been out visiting different areas of the Group. Several common themes had been identified during the briefings, and a "frequently asked questions" sheet was being developed. Staff members who had a specialist level of expertise, for example health and safety would also be assisting with the process moving forward.
752/26	The Group Chief People Officer explained that from a contractual perspective, staff members would see no change with regards to their terms and conditions of service.
753/26	The Group Director of Communications and Engagement offered that staff engagement would continue, and change champions had been identified to resolve topics and themes.
754/26	Mr Herbert offered that he would remain on the Single Organisation Oversight Group to provide independent scrutiny from a governance perspective to ensure all risks identified were being monitored and the correct governance structures were in place moving forward. The Board: • **Received the report** • **Received the communications and engagement go live document** • **Acknowledged progress on the delivery of the programme plan**
	Item 9 Risk and Assurance
755/26	**Item 9.1 Group Risk Management Report** The Group Chief Clinical Governance Officer presented the report in relation to very high and high risks across the Group, which had also been reviewed by the Committees. There had been a steady reduction in high risks across the Group, which demonstrated an active risk management process was in place.

756/26	The Group Chief Clinical Governance Officer explained that at the August Integration Committee discussion had taken place regarding the ability to undertake all areas of innovation at the same time which had a score of 25, due to external support this had reduced to a score of 15.
757/26	The Executive team had agreed to review the risks as part of the work for the single organisation to reconfirm that those risks were rated adequately on the Risk Register.
758/26	In terms of the risks for each Committee, the Group Chair offered that it was important to ensure that risks were captured appropriately and that time was being spent focussing on the correct areas and risks.
759/26	Mr Connolly confirmed that the Quality and Integration Committees were sighted on the Risk Register and used the document as a guide for focussed discussions.
760/26	Ms Cecchini offered that one area of focus for the Finance and Performance Committee was looking closely at risks outside of risk appetite, there were some risks associated with the condition of the estate which were being investigated further.
761/26	From a People Committee perspective, Professor Read offered that risks outside of the Risk Register were being looked at, including one area to ensure there was adequate support and communications to ensure staff members were kept informed of changes and ensuring there was adequate resource across the Group. Professor Read was impressed with how risks were identified and mitigated and the People Committee would keep a close eye on risks moving rapidly towards the merger.
762/26	Mr Herbert offered that the Audit Committee was keeping focus mainly on the risks sitting outside of risk appetite, particularly where there was limited movement on mitigating actions and whether the correct amount of attention was being paid to those areas. It was recognised that the Risk Register would evolve in respect of merger risks.
763/26	The Group Chief Executive assured Board members that the principal risks were well understood, were subject to robust governance and were being actively managed. The focus for Executives was to ensure improved outcomes for staff and patients. The Board: • **Received the report**
764/26	**Item 9.2 Board Assurance Framework** Board members considered the Board Assurance Framework (BAF) which had been reviewed through all Committees during July and August 2026.
765/26	The Group Director of Corporate Affairs offered that the Finance and Performance Committee was recommending a change to objective 1C, moving from green to amber which was reflected within the Committee upward report. Some areas were seeking to deescalate risks where tolerance was higher and Committees were continuing to review this as part of the monthly review process.

766/26	Mr Herbert offered that there had been good discussion on the BAF at the August Audit Committee meeting and Chairs of Assurance Committees had offered that they were content there was good discussion taking place within meetings and the BAF was being well utilised. The Board: • **Accepted the 2025/26 Board Assurance Framework which provided substantial assurance** • **Approved the changes to objective 1C**
767/26	**Item 9.3 Assurance and Risk Report from the Audit Committee** Mr Herbert provided the assurances received by the Audit Committee at the meeting held in August 2026 and the report was taken as read.
768/26	External Auditors had submitted an unqualified audit opinion for both organisations.
769/26	The first progress report had been received from the newly appointed Internal Auditors, and the Committee noted the position on overdue audit actions. Grip and control was being seen on the 2026/27 Audit Plan, and the final version had been presented and approved by the Committee.
770/26	A progress report had been received from Local Counter Fraud teams; the functional standard submission for both Trusts was Green.
771/26	In terms of compliance with governance arrangements, all Board members remained compliant with the Fit and Proper Persons Annual Assessment and a Group Legal Advice Policy was approved by the Committee.
772/26	The BAF and Risk Reports had been reviewed, and it was recognised that the BAF was being well utilised within Committees, however the Committee felt that there was an opportunity to better reflect updates to strengthen this as a standalone document.
773/26	In terms of overdue policies, whilst there had been improvement, concern remained over the number of overdue documents which had further deteriorated during the quarter and the improvement trajectory had been missed. This would be reflected upon within Performance Management Review meetings.
774/26	The Committee Chairs had expressed concern that flags were being seen in some areas which did not appear to triangulate with Committee reports. The Quality Committee Chair had agreed to discuss this with the Group Chief Clinical Governance Officer.
775/26	The Committee also considered the Draft Audit Committee Annual Report. The Board: • **Received the assurance report**

	Item 10 Strategic Aim 1 Patients
776/26	**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 July and August 2026 with the reports taken together and as read.
777/26	Mr Connolly advised that Duty of Candour remained high and previous concerns on the historic incident backlog had now significantly reduced.
778/26	In respect of infection, prevention and control, the C. difficle year to date position was 27, slightly ahead of trajectory.
779/26	The Committee had recognised the work around governance, surveillance and improvements, however also recognised the challenge relating to some consistent compliance with fundamental infection prevention control standards, in particular some issues identified in clinical practice through workforce management and infrastructure.
780/26	A further area of concern was ophthalmology, where despite best efforts there had been growth in overdue follow ups and first patient attendances. The Committee had acknowledged that this had been compounded by some longstanding workforce and pathway challenges. Challenges were also being seen on the pathway following the impact of the transition to the PSH. Some consultant recruitment had taken place however a risk to clinical capacity remained and the Committee had requested further oversight in respect of the patient safety element of the recovery trajectory.
781/26	A spot audit had been undertaken in July 2026 in respect of patient harm following the implementation and transition process to the PSH; no moderate or severe patient harm had been identified. Six formal complaints had been received however themes were multifactorial, and none were solely attributed to the transformation work within the Hub. The Committee would continue to maintain oversight as the new arrangements became embedded.
782/26	In relation to Maternity and Neonatal services, the Committee acknowledged that work was ongoing to understand and improve stillbirth rates, which remained slightly above trajectory and the Committee recognised the delivery of the NHSE 10 Point Plan and Maternity Care Bundle. The Committee was assured in respect of the overall benchmarking against the plan and recommended the position to the Board for approval.
783/26	With regards to year eight CNST standards, Mr Connolly explained that for safety action A, workforce – the neonatal service continued to demonstrate stable performance with compliance against quality in specialty trajectory which was being maintained.
784/26	Safety action B, training – compliance had been achieved across all staff groups with the training requirements during July 2026. The Committee had recognised that the next submission point in November posed a significant risk to CNST compliance

	despite the mitigations that were in place. The Committee would be maintaining oversight on this.
785/26	Safety Action C learning from review and investigation, Mr Connolly advised the Board that there had been five maternity and neonatal safety incident cases within the year eight reporting period, three of which had been referred through the early notification scheme. Duty of Candour had been completed for all cases, both written and verbal. The quarterly learning and action thematics would be received at the September Committee meeting.
786/26	Safety Action E, Maternity Care Bundle had been reported in the upward report, and the organisation was now fully compliant with all six elements of the Saving Babies Lives bundle.
787/26	An assurance visit from NHS Resolution had also been undertaken which was highly reassured by maternity services, preparedness, engagement and governance arrangements. Formal feedback was anticipated, however there was strong recognition of the quality improvement work that had been undertaken.
788/26	Mr Connolly also drew attention to a theme throughout July and August relation to some medical engagement, particularly with regards to safeguarding training in ED and non-compliance with some of the basic training requirements, which was currently at an unacceptable level. The Committee had requested urgent action from the Group Chief Medical Officer and medical leadership to improve the compliance position.
789/26	A new risk had been added to the Risk Register regarding orthodontics, which was currently scored at 20, and a focussed discussion would be held at the October Committee meeting.
790/26	The Committee was also in full support of the direction of travel in relation to transitional care beds, however explicit assurance had been requested regarding clinical responsibility which had been received post meeting. Further information had also been requested on the quality of care received by patients transferred into those beds and further assurance would be provided to the Committee.
791/26	2025/26 Annual Reports were also presented to the Board for both sides of the Group for Infection Prevention and Control, Complaints and Safeguarding and Vulnerabilities.
792/26	The Group Chief Nurse explained that relating to the 2025/26 Annual Report for Infection Prevention and Control, offering a healthcare associated infection perspective for E-Coli and C. dificile work was continuing to ensure learning was embedded. 65 outbreaks had been managed through the year, and the Group Chief Nurse drew attention to the strength and governance within Infection Control and improvement work that had been undertaken with the teams to improve fundamentals of care and manage outbreaks. Additional work would be undertaken during the year to further improve the position.

793/26	In relation to the 2025/26 Complaint Annual Reports, the Group Chief Clinical Governance Officer offered that significant work had been undertaken by the complaints teams in responding to concerns raised by patients and families.
794/26	The positive impact of learning from complaints was highlighted, with actions resulting in service improvements both within individual organisations and across the Group.
795/26	The Group Chief Clinical Governance Officer also drew attention to the reduction in the rate of reopened complaints compared with the previous year, providing assurance that concerns were increasingly being resolved effectively at the first stage of the complaints process.
796/26	Despite an increase in complaint volumes at ULTH, performance remained strong, with 100% of complaints acknowledged within three working days and 80% responded to within the timescales agreed with complainants. At LCHS, 100% compliance with complaint acknowledgements within three working days was maintained, with 69% of complaints responded to within agreed timescales.
797/26	The integration of the complaint's teams and the implementation of a single Group-wide process was supporting improvements in consistency and performance. The Group Chief Clinical Governance Officer provided further assurance that additional improvements were expected during the coming year as the arrangements continued to mature.
798/26	With regards to the Safeguarding and Vulnerabilities Annual Report, the Group Chief Nurse offered that statutory responsibilities continued to be met in relation to safeguarding children, young people and adults. The Annual Report also covered responsibilities relating to domestic abuse, Prevent, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), mental health and learning disability.
799/26	Safeguarding activity across Lincolnshire remained increasingly complex, with growing numbers of cases involving domestic abuse, self-neglect and exploitation. Despite these challenges, assurance was provided that safeguarding training compliance remained strong overall, particularly for Level 1 safeguarding, Prevent training and executive-level training, although some areas requiring improvement continued to be monitored.
800/26	The Group Chief Nurse explained that key priorities for the coming year included strengthening a personalised safeguarding approach, improving compliance with safeguarding training and supervision, embedding consistent Mental Capacity Act practice across services, and ensuring learning from safeguarding investigations was effectively translated into service improvements.
801/26	The Group Chair offered that ophthalmology services remained a key clinical risk and some issues connected with the PSH were being addressed with progress continuing to be monitored.
802/26	The Group Chair also acknowledged that the medical staffing safeguarding training issue would be triangulated with the People Committee.

	The Board: • **Received the assurance reports** • **Received the 2025/26 Annual Reports as presented**
803/26	**Item 10.2 Maternity and Neonatal 10 Point Plan** The Group Chief Nurse provided an update on maternity services performance against the national three year delivery plan and 10 Point Improvement Plan, benchmarked against national requirements.
804/26	The Group Chief Nurse offered that there were several areas providing strong assurance, alongside a small number requiring further development and support at system and national level.
805/26	The Group Chief Nurse explained that accountability for delivery was jointly shared between herself and the Group Chief Medical Officer working closely with Care Group leadership. To strengthen oversight and assurance, the Group Chief Clinical Governance Officer had been appointed as a Trusted Board Assessor for maternity services.
806/26	The area of listening to women and families remained red rated, reflecting the need to strengthen mechanisms for capturing and responding to real time feedback. Work was also underway to enhance processes for gathering and acting on the experiences of women and families, and an updated improvement plan would be presented in December 2026.
807/26	In respect of Martha's Rule, the Group Chief Nurse advised that associated call for concern arrangements had been implemented within maternity services. Further national development work was required to fully integrate the requirements with the BadgerNet system and national software solutions were currently being developed to support compliance.
808/26	The staff listening domain was also red rated and Board members were advised that a programme of engagement activity had been relaunched, including staff listening events, leadership walkarounds and enhanced engagement led by the Director of Midwifery. Progress was also being monitored through maternity governance structures.
809/26	Performance against elements of the national maternity care bundle demonstrated good areas of practice alongside gaps requiring broader system wide support, particularly through stronger partnership working with primary care colleagues. The Group Chief Nurse offered that quarterly benchmarking reports were being developed to support oversight through the Maternity and Neonatal Oversight Group (MNOG) and would move from bi-monthly to monthly meetings to provide enhanced assurance.
810/26	In relation to the home birth service, Mrs Jackson questioned the red rated areas and asked if there was any cause for concern. The Group Chief Nurse responded that with home births reviews were undertaken to provide assurance on staff compliance

	and training, however there were several vulnerabilities associated with this which would form part of the formal improvement plan to provide robust reporting.
811/26	The Group Chair acknowledged that the national reporting template had only recently been released and welcomed the proactive approach taken to provide early assurance to the Board. The Board: • **Approved the Maternity and Neonatal 10 Point Plan Benchmarking** • **Agreed to receive a further benchmarking update in December 2026**
812/26	**Item 10.3 LCHG 2026-2030 Clinical Service Strategy** The Group Chief Integration Officer presented the 2026-2030 Clinical Service Strategy, which had received extensive discussion at a recent Board Development Session.
813/26	The Strategy outlined the plan for the next four years and provided overarching navigation for delivery plans which sat beneath. Work had been undertaken on the Strategy in terms of understanding population needs and responding to those over the next four years.
814/26	The document served a dual purpose and was also the clinical operating model and followed the three pillars.
815/26	The Group Chief Executive welcomed the Strategy and offered that this was a clinical blueprint for the future organisation, which set out the ambition and desire. The Strategy had been shaped by patients and colleagues and reinforced the acute hospital being at the centre of delivery.
816/26	The Group Chief Nurse offered that overall the Strategy set clear direction on ambition and digital and work had been undertaken to ensure quality and safety was more visible, this would also ensure patient outcomes were more transparent. The Board: • **Approved the 2026-203 Clinical Service Strategy**
817/26	**Item 10.4 Finance Briefing** The Group Chief Finance Officer offered a summary of performance at month four for 2026/27, which provided reasonable assurance and demonstrated a year to date deficit of £7.4m, representing performance £0.2m better than plan. Board members were advised that the Group remained on track to deliver its planned year end position, subject to the successful delivery of efficiency programmes and the effective management of workforce expenditure.
818/26	The Group Chief Finance Officer highlighted three critical areas of focus with activity delivery reported to be £2.9m below plan and was largely driven by outpatient performance. The Chief Operating Officer's team had implemented a recovery plan aimed at maximising elective activity and outpatient income opportunities.

817/26	Efficiency schemes had delivered £25.7m year-to-date, £1.1m behind plan due to slippage in several key schemes. The maturity of plans continued to improve, with 77% of identified schemes fully developed, compared to a target of 80% by September. Deep-dive review sessions were planned to further strengthen and develop schemes.
818/26	From a workforce perspective, substantive staffing levels remained stable. However, temporary staffing expenditure increased during months three and four. The HR team were working closely with Care Groups to strengthen controls and implement actions to reduce temporary staffing reliance.
819/26	The Group Chief Finance Officer explained that capital programme expenditure was behind plan, reflecting the phasing of expenditure and challenges relating to project timelines. Variances continued to be monitored through the Finance and Performance Committee to maximise capital delivery by year-end.
820/26	The cash position across the Group was reported as £33.6m, £13.6m below plan. This reflected earlier than anticipated settlement of capital creditors together with the impact of the year to date financial performance on cash balances.
821/26	The Group Chief Finance Officer offered that submissions had been made for both organisations' cost collection returns, together with the required corporate cost return, in line with national requirements.
822/26	Ms Cecchini highlighted an amendment to the BAF, with the rating moving to an amber rating. This reflected the achievement of key milestones within the efficiency programme, the implementation of activity recovery plans, and emerging evidence of improved workforce management. It was acknowledged, however, that significant work remained to provide full assurance over delivery, with further progress expected during September and October 2026. The Board: • **Received the report noting the reasonable assurance** • **Noted the three key areas of internal focus, delivery of variable income, efficiency target and workforce controls** • **Noted the submission of the 2025/26 National Cost Collection**
823/26	**Item 10.5 Assurance and Risk Report Finance and Performance Committee** Ms Cecchini provided the assurances received by the Finance and Performance Committee, at the meetings held during July and August 2026; the reports were taken as read.
824/26	Ms Cecchini outlined that the Committee had received post-investment reviews relating to the Arrhythmia Nurse Business Case and the Lincoln Community Diagnostic Centre (CDC). The Committee emphasised the importance of clearly defining objectives and measurable outcomes within business cases to strengthen future post-investment evaluations and demonstrate realised benefits.

825/26	Operational performance remained strong, particularly across out of hospital services. UTCs continued to perform well, although performance remained just below the Group's requirement to achieve 98% compliance with the four-hour standard.
826/26	Continued success in maintaining community elective waits within 12 months was acknowledged by the Committee.
827/26	Challenges remained across acute services, particularly within diagnostics and cancer performance, although some areas of improvement were reported. The Committee had received a tumour-site deep dive in July and discussed the frequency and format for updates on performance across other tumour sites. Diagnostic pressures continued for several services, including audiology, where external providers had been commissioned to support demand. The Committee had acknowledged these challenges were being experienced nationally.
828/26	The Committee expressed concern regarding performance against the fractured neck of femur pathway, where the target for treatment within 48 hours was currently not being achieved. A recovery trajectory was expected in September 2026. The alignment between this issue and the Group's clinical strategy was noted by the Committee, particularly the priorities relating to frailty and falls prevention.
829/26	An update on Estates compliance highlighted continued positive progress, including improvements in statutory compliance. The Committee also received an Emergency Preparedness, Resilience and Response (EPRR) update, which provided assurance regarding current arrangements. Further clarification on the actions required to return the service to a substantial assurance rating had been requested. Key risks identified included Business Continuity Plans (BCPs) and challenges in meeting national lockdown requirements across some sites.
830/26	The Committee received a report from the Health and Safety Committee, which provided reasonable assurance overall. Areas requiring further attention included violence and aggression training and the use of de-escalation techniques. Members agreed to refer concerns to the Quality Committee regarding the management of patients presenting with mental health needs on acute sites, and the need for clarity between providers to ensure patient safety responsibilities were clearly understood.
831/26	Reports from the Information Governance Group (IGG) and Cyber Security lead provided reasonable assurance regarding information governance and cyber resilience. The Committee welcomed the positive actions being taken to mitigate risks associated with the increasing global cyber threat.
832/26	Cross-committee referrals included updates from the People Committee relating to mandatory training compliance, violence and aggression training, and workforce development. The Committee had also requested further oversight of sonographer training and workforce pipeline development in response to diagnostic service pressures, including those affecting ultrasound services. The Board: • **Received the assurance reports**

	Item 11 Strategic Aim 2 People
833/26	**Item 11.1 Assurance and Risk Report People Committee** Professor Read provided the assurances received by the People Committee, at the meetings held during July and August 2026 and the reports were taken as read.
834/26	Members reviewed updates on safer staffing and workforce and received assurance regarding medical workforce arrangements. Concerns were raised regarding the continued use of agency staffing and several persistent workforce gaps. Assurance was provided on the actions being taken to address these challenges and reduce agency reliance.
835/26	In relation to nursing safer staffing, the Committee received assurance that appropriate arrangements remained in place to maintain patient safety. Updates were provided on the nursing workforce establishment, including progress with Band 5 nursing job evaluations, and the Committee reviewed the Annual Safe Staffing Assurance Report.
836/26	A detailed discussion took place regarding education oversight and governance. While partial assurance was received in several areas, members highlighted concerns relating to medical education. Further work was underway with the Chief Medical Officer to review job planning arrangements for clinicians supervising resident doctors and to strengthen educational oversight. The Committee also discussed resident doctor induction processes and feedback received from trainees.
837/26	The Committee received an update from the Freedom to Speak Up (FTSU) Guardians, where positive support was being provided to staff and a continued increase in cases was noted. Committee members welcomed this as evidence of a strengthening and increasingly positive speaking-up culture across the Group.
838/26	An update had been received from Library Services, highlighting the contribution being made to research, innovation and education across the Group.
839/26	Progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) was reviewed, with members noting positive trajectories in several areas while acknowledging that further improvement was required.
840/26	The Committee had agreed that key areas of ongoing focus should include medical education, job planning arrangements, and medical workforce safer staffing.
841/26	The Chief People Officer provided an update on staff exclusions and offered assurance that arrangements were in place to oversee and expedite outstanding cases wherever possible, whilst ensuring the health and wellbeing support needs of affected staff continued to be met. The Board: • **Received the assurance reports**

842/26	**Item 11.2 Workforce Race Equality Standards (WRES) and Workforce Race Disability Standards (WDES) Reports and Action Plans** The Group Chief People Officer presented the annual Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) reports for both LCHS and ULTH.
843/26	The Group Chief People Officer offered that the reports set out progress made over the previous year, including the work undertaken through staff networks and wider workforce equality programmes, and demonstrated compliance with national reporting requirements and statutory obligations.
844/26	The reports included detailed data analysis, trend information and action plans for the next three years.
845/26	Continued progress in relation to the WDES metrics was acknowledged by Board members, particularly improvements in disability disclosure rates for both organisations, reflecting sustained investment and engagement in this area. The Group Chief People Officer highlighted ongoing concerns regarding disabled staff perceptions of career progression opportunities and aspects of staff experience, which would remain areas of focus moving forward.
846/26	The WDES report highlighted progress against several areas previously identified for improvement, the continued work planned to address remaining inequalities and further strengthen workforce inclusion.
847/26	The Board received the annual WRES Report, the Group Chief People Officer detailed progress against the standalone and combined Group action plan, now in year two of a three-year programme.
848/26	Both organisations had made good progress in improving workforce representation and reducing workforce inequalities, whilst recognising that some challenges remained and continued to require focused attention.
849/26	The Group Chief People Officer explained that several actions were underway as part of the year two improvement programme, including implementation of recommendations arising from the Lord Mann Review and other initiatives aimed at strengthening equality, diversity and inclusion across the workforce. The Board: • **Approved the Workforce Race Equality Standards (WRES) and Workforce Race Disability Standards (WDES) for publication**
850/26	**Item 11.3 Lord Mann Review** The Group Chief People Officer presented the report which offered an update on correspondence received on 4 June 2026 from the Chief Executive and Director General for People at NHS England, which highlighted the opportunity for NHS organisations to move from commitment to a more evidence based approach in delivering improvements in equality, diversity and inclusion (EDI).

851/26	The Group Chief People Officer explained that the Group had responded positively to the recommendations arising from the review and all required submissions had been made. A formal implementation programme had been established to oversee delivery of the recommendations.
852/26	The Group Chief People Officer offered that appropriate governance arrangements were in place with action plans approved and progress would be monitored through the People Committee.
853/26	There would be continued focus on improving staff experience, organisational culture and workforce inclusion. The Group Chief People Officer explained that much of this work aligned with activity already underway prior to the review, however further actions were now being implemented to strengthen progress and ensure sustainable improvement. The Board: • **Received the report** • **Acknowledged that implementation of the recommendations would continue to be monitored by the People Committee**
854/26	**Item 11.4 Ward Establishment Review** The Group Chief Nurse presented the paper which detailed the outcome of the Group wide nursing establishment review, which considered 65 services within ULTH and 35 services within LCHS, using consistent methodology across both organisations.
855/26	The review had highlighted workforce pressures in some areas, including sickness absence, vacancies and skill mix challenges and the ongoing work to support services in addressing these pressures and maintaining safe staffing.
856/26	The review panel had supported proposed growth of 6.75WTE posts across ULTH Wards including Harrowby Ward at Grantham Hospital, due to evidence of increasing patient complexity and the need to strengthen leadership capacity within services.
857/26	The panel had not supported growth within community services at this stage, recognising the significant ongoing transformation of district nursing services. The Group Chief Nurse advised that work was underway to review the district nursing catalogue, transform service delivery models and strengthen the supporting workforce and activity data to provide a more robust evidence base for future reviews.
858/26	The panel had also considered staffing in the Emergency Departments (EDs), and further work was required in relation to workforce availability and skill mix at Lincoln ED. At Pilgrim ED, structural changes to support patient flow were being progressed through existing operational governance groups. The panel had recommended that the proposals should not proceed at this stage and further workforce modelling should be undertaken with findings to be brought back for review in six months.

859/26	The Group Chief Nurse explained that the review identified an investment requirement of £155k, which would be reduced to £110k through the delivery of Cost Improvement Programme (CIP) savings.
860/26	The importance of ensuring workforce establishment reviews provided assurance that staffing capacity was aligned to service demand and supported targeted investment where required was acknowledged. The Group Chief Nurse explained that the Quality Committee had reviewed the proposals in detail, supported the recommendations in principle and recognised the need for further work to assess community workforce requirements once current transformation activity had stabilised. The Board: • **Received the report and approved the recommendations**
	Item 12 Strategic Aim 3 Population
861/26	**Item 12.1 Assurance and Risk Report from the Integration Committee** Mr Connolly provided the assurances received by the Committee at the meetings held in July and August 2026.
862/26	Mr Connolly advised that the Committee had received assurance on progress across the Integration Committee transformation agenda where there was clear evidence that several programmes were moving beyond strategy development and organisational integration into delivery and benefits realisation.
863/26	The Partnership Plan had been reviewed and its importance in supporting the strategic shift towards prevention and partnership working was recognised. Further work was required to establish how outcomes and benefits from the partnership arrangements would be measured and evaluated.
864/26	The Committee received assurance regarding the capital programme and wider estates transformation agenda. A proposal to relocate the Skegness Urgent Treatment Centre (UTC) had been considered, recognising the challenges associated with the current estate. Mr Connolly advised that the proposal was supported in principle alongside the Community Diagnostic Centre (CDC) development, subject to the completion of the appropriate approval processes.
865/26	An update on the Care Closer to Home programme highlighted significant progress within the Hospital at Home workstream. The service was now delivering approximately 13,000 contacts per month, with around 11,000 residents receiving alternatives to Emergency Department attendance. The Committee had recognised this as a strong example of transformation moving into delivery and demonstrating measurable benefits. Further developments included the integration of medical services and implementation of phase one of the IV Therapy pathway, which had enabled 237 residents to receive care safely at home, with the potential to release approximately 1,400 bed days. Committee members had welcomed this as an important and promising programme.

866/26	Positive assurance had been received from a deep dive into Health Inequalities, with progress from programme establishment to measurable improvement. Care Groups were embedding health inequalities considerations within service planning and delivery, supported by a growing network of over 100 Health Inequalities Champions across the Group.
867/26	Limited assurance was received in relation to the Paediatric ADHD Service, reflecting the scale of current demand and concerns regarding children reaching transition age before receiving intervention. Risk assessment work was underway to determine appropriate next steps and support service improvement.
868/26	The Committee reiterated its focus on evidencing improvements arising from transformation activity, with further updates scheduled through both the Integration Committee and Quality Committee.
869/26	Regarding the Digital Programme, the EPR programme remained on track for the planned October go-live date. The programme continued to be rated amber, with substantial assurance provided on programme delivery. The Electronic Document Management System (EDMS) implementation remained on schedule, however staffing pressures and the impact on document scanning capacity continued to be monitored. The Committee also supported the continued exploration of ambient voice technology as part of the wider transformation agenda.
870/26	Mr Connolly highlighted the significant scale and pace of transformation activity currently being delivered across the Group.
871/26	The Group Chief Integration Officer offered that an external review of EPR readiness had rated the programme amber/green, representing the strongest assurance rating expected at this stage of implementation. It was also noted that a phased approach had been adopted to aspects of the digital programme to ensure readiness and mitigate operational risk ahead of go live.
872/26	The Group Chief Integration Officer explained that in terms of the Digital BAF, the Group's stated risk appetite may not currently align with the risk ratings reported. Committee members had agreed this should remain under review for further consideration. The Board: • **Received the assurance reports**
873/26	**Item 12.2 Q1 Strategy Delivery Report** The Group Chief Integration Officer presented the progress update for quarter one and explained that the report triangulated quarter one performance against current trajectories, operational performance indicators and assurance reports received through Committee structures.
874/26	Areas of concern included C. difficile performance and diagnostic performance, with associated workforce pressures, including vacancies and sickness absence, reflected consistently across performance dashboards and Committee reporting.

875/26	Assurance was provided that progress was being made against the quarter one delivery plan and the report provided a high level of assurance regarding delivery of commitments made, whilst also highlighting areas of further improvement.
876/26	With regards to workforce indicators, the Group Chief People Officer offered that due to changes made to the appraisal reporting window to align with arrangements across both organisations, this had resulted in some delays in appraisal recording. Work was underway through the Performance Review Meetings (PRMs) to address this.
878/26	The Group Chief Nurse informed Board members of the continued focus on sickness management with targeted support being provided through collaborative work involving operational leads, occupational health and organisational development teams to support areas experiencing higher levels of sickness.
879/26	The Group Chief Nurse also offered that from a Quality Committee perspective, there had been recent deep dives into C. difficile performance, medicines safety and pressure ulcer performance. The reviews had highlighted areas of declining performance and emerging risks, however provided assurance that improvement actions and enhanced oversight arrangements were in place.
880/26	The Group Chair acknowledged that the deep dives formed an important part of the Group's assurance framework and supported ongoing monitoring of quality and safety performance. The Board: • **Received the report**
881/26	**Item 13 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.
882/26	The Group Chief Integration Officer explained that an Artificial Intelligence triangulation tool was being developed which would link in with the risk report and BAF and further highlight any gaps.
883/26	From a complaints perspective, the Group Chief Clinical Governance Officer explained that the Group had an aspiration target of 100% to respond in a timely manner. The Complaints Annual Reports for both organisations had highlighted that ULTH had ended last year at 80% and ULTH 84.5%, therefore the targets were being increased.
884/26	An amber rating for Duty of Candour had also been raised at the last Quality Committee where it was noted that performance was not at 100% as per aspirations. The Group Chief Clinical Governance Officer offered that this was due to a timing issue for reporting and both organisations had achieved 100% for Duty of Candour.

	The Board: • **Received the Integrated Performance Reports noting the moderate assurance**
885/26	**Item 14 Board Forward Planner** The Forward Planner was presented and received for information. The Board: • **Received the Board Forward Planner**
886/26	**Item 13 Any Other Notified Items of Urgent Business** No further items were discussed.
887/26	The next scheduled meeting will be held on Tuesday 3 November 2026 via MS Teams live stream.

Voting Members	**5 May 2026**	**7 July 2026**	**1 Sept 2026**									
ULTH/LCHS												
Rebecca Brown	X	X	X									
Neil Herbert	X	X	X									
Dani Cecchini	X	X	X									
Jim Connolly	X	X	X									
Vicki Wells	X	X	A									
Karen Dunderdale	X	X	X									
Daren Fradgley	X	X	X									
Nerea Odongo	X	X	X									
Ciro Rinaldi	X	A	A									
Paul Antunes Goncalves	X	X	X									
Jamie Read (ULTH only)	A	A	X									

NHS
Lincolnshire Community and Hospitals NHS Group

Group Chief Executive's Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*6*
Report title	*Group Chief Executives Board Report*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information*
Accountable Director	*Karen Dunderdale, Group Chief Executive*
Author(s)	*Karen Dunderdale, Group Chief Executive* *Gemma Coupland, Executive Business Manager*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	
Prior approval process, if applicable	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to note the update on the key points from September and October 2026*

Assurance Rating Key:

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

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

2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
2c: Nurture compassionate and diverse leadership	
2d: 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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

System Overview

a) Sir Jim Mackey, Chief Executive Officer of NHS England, wrote to all NHS trusts, integrated care boards and primary care organisations regarding the unauthorised, inappropriate and unjustifiable access to confidential patient information. He made clear that such access is unlawful, undermines public confidence in the NHS and, in almost all circumstances, should be regarded as gross misconduct. The Group fully supports this zero-tolerance position and is reinforcing colleagues' responsibilities for information governance, confidentiality and appropriate access to patient records, alongside robust processes to investigate and act where necessary.

b) The publication of the Thirlwall Inquiry report in September 2026 represents a significant moment for the NHS and reinforces the importance of an open, transparent and safety-focused culture across all organisations. The Inquiry examined the events surrounding failures in neonatal services at the Countess of Chester Hospital and the wider organisational and system response to concerns that were raised over a sustained period. NHS England has written to all trusts and integrated care boards setting out immediate actions and expectations, including the review of safeguarding arrangements, staff training, bereavement care, and the importance of ensuring concerns are identified, escalated and acted upon promptly. The Group welcomes the publication of the report and will continue to review the recommendations in detail, assessing local arrangements and implementing any required actions to strengthen patient safety, organisational learning and a culture where concerns are listened to and acted upon without delay.

c) NHS England has written to all trusts to confirm plans to implement Martha's Rule across all Emergency Departments (EDs) in England by March 2028, extending the current process available within adult and children's inpatient services. The Group welcomes this development, which will strengthen early recognition of deterioration and give patients, families, carers and staff a clear route to raise concerns and be heard in decisions about care.

Group overview

a) Services across the Lincolnshire health and care system remained exceptionally busy throughout September and October. During September, urgent and emergency care services experienced a 13% increase in attendances, placing significant pressure across the system. Despite these sustained operational challenges, Emergency Department teams have continued to provide a high standard of care, demonstrating remarkable professionalism, resilience and commitment to patients. Colleagues across our emergency care pathways have worked tirelessly to maintain patient flow, prioritise those with the most urgent clinical needs, and support safe and effective care delivery during periods of increased demand.

b) The NHS National Oversight Framework (NOF) Quarter 1 ratings were published in September 2026. For this quarter United Lincolnshire Teaching Hospitals NHS Trust (ULTH) remained in Segment 4, ranked 124th out of 134 peer trusts. Whilst this reflects the continued operational and performance challenges facing the organisation, improvement activity remains focused on addressing key areas of concern and delivering sustainable performance

improvements. Lincolnshire Community Health Services NHS Trust (LCHS) has improved to Segment 2, ranked 26th out of 58 peer trusts, reflecting continued strong performance and positive progress across a range of quality, operational and organisational measures.

c) The Group continues to engage regularly with NHS England Midlands through the monthly Provider Review Meeting process, providing oversight and assurance on operational, financial, workforce and quality performance. The most recent review focused on year-to-date delivery against the 2026/27 Operating Plan, including progress against financial recovery trajectories, efficiency and productivity plans, operational performance, elective recovery, cancer and diagnostic standards, community waiting times, and developments within the Patient Services Hub. These discussions continue to provide constructive challenge and support, ensuring the Group remains focused on delivering safe, high-quality services and sustainable organisational improvement.

d) Following Care Quality Commission (CQC) inspections undertaken during August and September 2026, on 16 September 2026, the CQC served a Section 29a Warning Notice on United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for failing to meet the regulations related to the safe management of medicines within the Emergency Department at Pilgrim Hospital. Since the inspection, the Group has taken immediate actions to address the concerns raised, with strengthened governance, assurance and monitoring arrangements established. Progress is being closely monitored through the Trust's quality and performance oversight processes to ensure that all required actions are completed and sustained, and that patient safety remains a key priority.

e) United Lincolnshire Teaching Hospitals NHS Trust's (ULTH) Nervecentre Electronic Patient Record (EPR) successfully went live across all inpatient and emergency departments on 13 October 2026. The implementation has progressed smoothly, with colleagues adapting quickly to new ways of working. This represents a significant milestone in the Trust's digital transformation journey and a major step forward in modernising how care is delivered across our acute services. The EPR supports more efficient clinical workflows, reduces duplication, improves access to real-time patient information and enables more care to be delivered at the bedside. It will also provide patients with greater access to and involvement in their healthcare, supporting the ambitions set out in the NHS 10-Year Health Plan.

f) Following the announcement of our intention to merge our two organisations and create a new, single NHS Trust, we launched an engagement exercise in early September. While the merger is a structural merger of organisations and therefore doesn't constitute a formal requirement to consult, we are keen to hear the views of our staff, residents and stakeholders. The engagement exercise runs until Monday 30 November and enables people to share their views on the planned merger, and more broadly, on how health and care services could be delivered differently in the future. It is about listening and understanding what matters most to our staff, residents and stakeholders. At the time of writing, the Full Business Case has been completed ready for submission to NHS England at the end of October.

g) The Group formally launched its Work Well Plan, which is our commitment to making Lincolnshire Community and Hospitals NHS Group a place where every colleague can thrive,

from the moment they join, throughout their development and career with us. The plan provides the strategic framework for developing, empowering and retaining great people and is underpinned by five key pillars: Join Well, Grow Well, Work Well, Belong Well and Stay Well. By helping colleagues feel valued, supported and empowered, we can build strong teams, improve staff experience and continue to deliver safe, high-quality care for the people of Lincolnshire. As part of the early delivery of the Plan, the Group's annual staff flu vaccination programme launched on 2 October, supporting the Stay Well pillar by encouraging colleagues to protect their health and wellbeing during the winter period, reducing the risk of illness-related absence and helping to maintain high-quality patient care.

h) The team behind Lincolnshire's Rapid Access Angina Clinics has received national recognition, winning the Nurse-Led Patient Safety Initiative of the Year at the HSJ Patient Safety Awards 2026. Developed through collaboration between Lincolnshire Community and Hospitals NHS Group and NHS Lincolnshire ICB, the innovative service enables patients with suspected angina to be assessed, undergo a CT scan and receive results on the same day. By redesigning pathways and making greater use of community diagnostic centres, the team has significantly reduced waiting times, improved access to diagnostics, reduced missed appointments and supported earlier diagnosis and treatment. Importantly, this has contributed to reducing emergency hospital admissions for chest pain and improving outcomes for patients at risk of heart attack and heart failure. The award is a testament to the dedication, innovation and partnership working of colleagues across cardiology, radiology, diagnostics and primary care who have delivered a safer and more responsive service for patients.

i) The Group Staff Awards took place on Friday 16 October 2026, bringing together colleagues from across Lincolnshire Community and Hospitals NHS Group to celebrate the outstanding achievements, dedication and commitment of our workforce. The awards provide an opportunity to recognise individuals and teams who consistently go above and beyond to deliver exceptional care and services for patients, support their colleagues and demonstrate the Group's values. The breadth and quality of nominations received highlighted the significant contribution that staff, volunteers and teams make every day, often in challenging circumstances, to improve patient experience, outcomes and the delivery of safe, high-quality care. The event served as an important opportunity to acknowledge and thank colleagues for their professionalism, compassion, innovation and commitment to making a positive difference to the residents of Lincolnshire.

j) I was pleased to welcome Baroness Merron, Minister for Women's Health and Maternity, to the Group during October for a visit to the Lincoln Breast Care Unit. The visit coincided with the launch of a new partnership between the Department of Health and Social Care and Breast Cancer Now, which aims to improve awareness of the signs and symptoms of breast cancer, encourage earlier presentation and diagnosis, and provide enhanced information and support for women during and after treatment. The visit provided an opportunity to showcase the excellent care delivered by our breast care services and to discuss the important role of early detection and patient support in improving outcomes for women.

k) Finally, I am pleased to announce that, following a robust external recruitment process, Professor Ciro Rinaldi has been appointed as substantive Group Chief Medical Officer. Having served as Interim Group Chief Medical Officer since April 2026, and previously as Deputy Chief Medical Officer, Ciro brings significant expertise in clinical leadership, patient safety, quality improvement, research and service transformation. An active clinician and academic, he has led nationally and internationally recognised research in cancer care, data and artificial intelligence. In his substantive role, Ciro will provide professional leadership for the medical workforce across the Group, supporting the delivery of high-quality, safe and increasingly integrated services as we progress towards becoming a single organisation.

NHS
Lincolnshire Community and Hospitals NHS Group

Move to a Single Organisation: Single Organisation Programme Oversight Group Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*6.1*
Report title	*Move to a Single Organisation*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Discussion* • *Assurance*
Accountable Director	*Rebecca Brown, Group Chair* *Professor Karen Dunderdale, Group Chief Executive*
Author(s)	*Professor Karen Dunderdale, Group Chief Executive* *Wendy Booth, Interim Governance Advisor*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable Assurance*
Prior approval process, if applicable	*Single Organisation Programme Oversight Group*
Financial implications, if applicable	*The financial implications (costs versus benefits) of the merger are captured as part of the Full Business Case*
Action / decision required	*The Group Board is asked to:* • note the discussions held at the September & October 2026 meetings of the Single Organisation Programme Oversight Group; • receive and note progress with delivery of the Single Organisation Programme Plan: no risks or issues escalated at this stage **(Appendix 1 refers);** • note the work which is underway to update the Transition Delivery Risk Log to include the outputs from the due diligence activity; • agree the need for any additional information, 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 whilst addressing our requirements for sustainability and our Green agenda	X
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	X
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	X
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	X
3c (iii): Enhance our research and innovation capability linked to our population health needs	X
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	X

Executive Summary

Background & Introduction

Following the Group Board's formal approval to seek the necessary external authorisation to become a single legal entity*, a Single Organisation Programme Oversight Group (the 'Oversight Group') was convened in October 2025 and meets monthly. The Oversight Group is supported by an external, Interim Governance Advisor. A member of the regional NHSE transaction team was co-opted on to the Oversight Group in November 2025.

This written Upward Report provides details of discussions held at the 14 September 2026 and 12 October 2026 meetings of the Oversight Group.

*[*Term 'single entity' changed to refer to 'single organisation']*

Oversight Group: 14 September 2026

Strategic Case: LCHG Response to NHSE Recommendations including Integration Delivery & Benefits Realisation Capacity

The Oversight Group received the updated draft response to the NHSE recommendations following their review of the Strategic Case, which had been strengthened to include the current internal and external support and resource to the programme and individual work streams.

The Oversight Group noted that discussions in respect of the additional internal resource to support clinical teams with integration delivery & benefits realisation and in respect of the benefits realisation model (how benefits will be quantified and how evidence of impact will be measured & reported) were being concluded and details would be included in the response to NHSE.

The Group Chair confirmed that capacity to support both 'business as usual' and the transaction process remained an area of focus for the Group Board and felt it was helpful to see the level of detail which had been included in the response on the current support and resource in place.

Transaction Lead Overview Report

The Group Deputy Chief Executive & Group Chief Integration Officer, in his new capacity as Transaction Lead, provided a verbal overview of programme delivery highlighting the following key points:

Due Diligence

- Due diligence reports remain draft with some elements of due diligence still being finalised particularly the legal due diligence (draft legal due diligence report not yet received).

- Final due diligence reports are scheduled to be submitted to the Group Board on 6 October 2026.

Post Transaction Integration Plan

- The development of the Post Transaction Integration Plan, alongside the Full Business Case remains the current priority: latest update shared. A key focus is required on chapters: 6 (corporate functions) 7 (clinical integration priorities), 8 (enabling strategies), 9 (operating model) & 10 (integration delivery & governance).

- Group Board approval of the Full Business Case & Post Transaction Integration Plan is scheduled for Tuesday, 27 October 2026.

- In respect of chapter 3 of the Post Transaction Integration Plan: strategy, vision & values, the Transaction Lead recommended and the Oversight Group agreed to retain the existing group strategy, vision & values which had only recently been finalised and reflect the aspiration to merge. It was agreed that the strategy, vision & values should be reviewed again once the trusts had merged.

Future 'Star Chamber' Events

- Following the success of the initial 'Star Chamber' events, which had been useful in helping to build the content and ownership of the Post Transaction Integration Plan and integration actions, it was agreed that further sessions should be arranged to occur after submission to NHSE of the Full Business Case and Post Transaction Integration Plan and prior to the next round of gateway meetings with NHSE (gateway meetings likely to include all board members).

Learning from Elsewhere

- Discussions continue with other trusts who have been through the transaction process to identify any learning on transaction planning & preparation. It was reported that example Full Business Cases had also been shared. The Group Chair expressed her gratitude to the trusts for sharing learning and Full Business Cases and commented that she would be keen in the future to support other trusts going through the transaction process.

The Transaction Lead advised that his overview reports would be written in future. The Transaction Lead's overview report was supplemented by the more detailed written reports and updates from work stream SROs and relevant others, as detailed below.

<u>Single Organisation Programme Plan & Transaction Timeline</u>

The Oversight Group received and reviewed the Single Organisation Programme Plan as of 4 September 2026, noting the continued good progress with achievement of the programme milestones. No risks or issues were escalated.

In respect of work stream 2 (corporate governance), the Oversight Group noted that the planned review of the board & board committee effectiveness had commenced. In respect of board effectiveness, the Group Chair confirmed that work was underway with NHS Providers to provide further input into the Board Development Programme; specifically, a reflections & preparedness session (i.e. where are we now & readiness for merger and beyond).

In respect of work stream 4 (communications & engagement), the Oversight Group noted that the Communications & Engagement Strategy had been approved by the Group Board on 1 September 2026.

The Oversight Group noted that further detail in respect of pre & post transaction milestones would be included within the Post Transaction Integration Plan over the coming weeks.

Due Diligence: Draft Reports

The Oversight Group received the draft due diligence reports although it was noted that the finance report could not been finalised until the financial modelling work was complete, the IG report was still going through the factual accuracy checking process and the legal due diligence report had not yet been received. SROs agreed that whilst there were 'no surprises' arising from the due diligence work, the process had been useful. The Group Chief Executive stated that she felt assured that the findings within the reports triangulated with internal intelligence. She also felt confident that whilst not all actions would be completed by the 1 April 2027, the group was on a journey and had a plan to address the outstanding risk issues.

It was agreed that the final due diligence reports would be shared with the Group Board.

Single Organisation Transition Delivery Risk Log

The Oversight Group received the Transition Delivery Risk Log, which it was noted would be updated to reflect the risks & mitigations identified from the due diligence programme.

PTIP: Refresh of Integration Principles

The Oversight Group reviewed the Integration Principles set out within the Strategic Case and considered the need for any amendments for Full Business Case stage, not least to ensure alignment with the organisation's strategic aims & objectives and the overarching aims of the merger.

The Oversight Group agreed that some minor amendments to the wording was required to ensure an emphasis on merger rather than group working. [**Note:** Changes to the Integration Principles were subsequently ratified through the Integration Committee and have been included within the Full Business Case']

Development of Full Business Case including Financial Modelling

The Oversight Group noted that work to develop the Full Business Case was 'on track'.

Communications & Engagement: Impact & Engagement Update

The Group Chief Communications & Engagement Officer provided a communications & engagement update and advised the Oversight Group that LCHG had moved from Phase 1: announcement phase to Phase 2: staff & public engagement phase. It was noted that key activities within Phase 2 would include: 'conversation in a box', the identification and

briefing of ‘clinical champions’, launch of the ‘Work Well’ Plan and canvassing for views on the new trust name.

Oversight Group: 12 October 2026

Transaction Lead Overview report

The Transaction Lead advised the Oversight Group that, since the previous meeting, programme activity had been focussed primarily on development of the Full Business Case and Post Transaction Integration Plan. He added that due diligence activity was largely complete and that identified risks would be incorporated within the Transition Delivery Risk Log and would also be captured within the Full Business Case.

The Group Chair and Group Chief Executive emphasised the importance of ensuring that supporting submissions were progressed in parallel with the Full Business Case and Post Transaction Integration Plan and that board members have sufficient time for review, challenge and assurance of the required documentation.

Single Organisation Programme Plan & Transaction Timeline

The Oversight Group received and reviewed the Single Organisation Programme Plan as of 5 October 2026, noting the continued good progress with achievement of the programme milestones. No risks or issues were escalated.

Full Business Case including Due Diligence Outputs: Risks and Mitigations

The Oversight Group received the draft Full Business Case and an overview of the document structure, key themes and areas of ongoing development including merger benefits.

The Oversight Group endorsed the draft Full Business Case: noting the need for further refinement prior to submission to the Group Board.

Post Transaction Integration Plan

The Oversight Group received the draft Post Transaction Integration Plan noting that work was continuing to consolidate contributions from all programme workstreams into a single integrated document in readiness for Group Board approval.

The Oversight Group acknowledged the importance of the Post Transaction Integration Plan in demonstrating how merger benefits would be delivered in practice and the need for implementation plans to be realistic, achievable and clearly linked to programme objectives.

In respect of organisational readiness, the Group Chief Executive emphasised the importance of ensuring that plans were sufficiently robust to support safe Day One operations. The Oversight Group noted that safe Day One readiness would include the harmonisation of organisational policies and providing clarity for staff and managers regarding the policies that would apply immediately following the transaction. The Group Chief Clinical Governance Officer confirmed that work is underway to strengthen policy alignment and document control arrangements.

The Oversight Group endorsed the Post Transaction Integration Plan: noting the need for further refinement prior to submission to the Group Board.

Communications & Engagement: Impact & Engagement Update

The Group Chief Communications & Engagement Officer provided a briefing on the communications & engagement activity undertaken since the previous meeting and advised that there had been continued progress in raising awareness of the Single Organisation Programme and supporting stakeholder understanding of the proposed merger. She added that communications & engagement had continued through a range of channels, including leadership briefings, targeted communications, team discussions and the 'conversation in a box' initiative. She further added that the feedback received through these activities had demonstrated a growing awareness of the programme whilst also identifying areas where further communication and clarification would be beneficial.

The Oversight Group also received an update on the recent staff pulse survey the results of which had provided valuable insight into staff understanding of the programme and had informed future engagement priorities. The Oversight Group noted that whilst there remained areas of uncertainty amongst staff, there was increasing recognition of the strategic rationale supporting the proposed merger.

The Group Chief Communications & Engagement Officer provided an update on external stakeholder engagement activity and advised that a recent stakeholder event had been attended by representatives from nineteen partner organisations. Feedback from attendees had been positive, with stakeholders expressing support for the ambition to create a single organisation and recognising the opportunities that greater integration could provide for patients, service users and communities across Lincolnshire.

The Oversight Group discussed the ongoing public engagement activity, including the naming consultation. The Group Chief Communications & Engagement Officer reported that more than 600 responses had been received and explained that the level of participation demonstrated significant public interest in the future organisation. She advised that analysis of the responses was underway and would help inform future recommendations.

The Oversight Group discussed the importance of continuing to engage proactively with staff, partners and stakeholders throughout the assurance process and agreed that communications activity would remain a critical component of successful delivery of the programme.

The Oversight Group noted the update and endorsed the continuing communications and engagement approach.

Review of Oversight Group Terms of Reference including Frequency of Meetings

The Oversight Group was asked by the Group Chair to consider whether the current frequency of Oversight Group meetings remained appropriate as the Single Organisation Programme approached some significant milestones, in particular the progression of the Full Business Case, Post Transaction Integration Plan and associated assurance processes.

Whilst the Oversight Group acknowledged the increasing pace of programme activity, there was broad agreement that the existing monthly meeting cycle continued to provide sufficient opportunity for scrutiny, challenge and assurance. It was also noted that a number of additional forums and programme governance mechanisms are already in place to escalate issues between meetings where required.

The Transaction Lead advised that the programme team would continue to monitor the volume and complexity of matters requiring Oversight Group consideration and that extraordinary meetings could be convened, if necessary, should programme circumstances require more immediate discussion or decision-making.

The Group Chair welcomed the discussion and agreed that maintaining flexibility would be important as the programme moved forward. She concluded that the current meeting frequency should remain unchanged, whilst recognising that this may need to be revisited as the transaction timetable is progressed.

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Group Board Action Required

The Group Board is asked to:

- note the discussions held at the September & October 2026 meetings of the Single Organisation Programme Oversight Group;
- receive and note progress with delivery of the Single Organisation Programme Plan: no risks or issues escalated at this stage **(Appendix 1 refers);**
- note the work which is underway to update the Transition Delivery Risk Log to include the outputs from the due diligence activity;
- agree the need for any additional information, action or assurance at this stage.

NHS
Lincolnshire Community and Hospitals NHS Group

Appendix 1
Single Organisation: Transaction Delivery Programme Plan & Timeline
As of 5 October 2026



Caring and building a healthier future for all

Executive Summary

- This report provides the programme plan in support of the move to a single organisation as of 5 October 2026 (although this document will remain 'live' and will inform the Full Business Case and Post Transaction Integration Plan, as appropriate)
- The programme plan has been developed and continues to be updated with work stream SROs, supported by the Interim Governance Advisor
- **Additional actions / milestones have been added to the October 2026 version of the programme plan: work stream 9 – People & Culture – to reflect the requirements in respect of TUPE**
- The timescales within the programme plan reflect a 1 April 2027 'Go Live' for the new single organisation (an updated transaction timeline summary – including key approval milestones – is included on **slides 3 & 4**)
- A summary of each of the work streams which make up the programme plan and the SROs is provided on **slide 5**. The work pillars under each work stream are provided within the relevant work stream section. As previously reported, Digital has become a separate distinct work stream reflecting its importance as a key enabler to the successful transition to a single organisation
- Whilst at this stage there is no specific 'clinical' work stream, the Group Chief Nursing Officer and Group Chief Medical Officer have been involved in the development of the plan and work streams and will continue to have clinical input into and oversight of the programme plan and are members of the Single Organisation Oversight Group
- The programme plan includes any residual or ongoing actions from the Group Development Programme Plan (which was formally closed at the Group Board meeting in public in March 2026). Where appropriate, timescales for these ongoing actions have been re-cast
- Work streams include key tasks / milestones pre and post transaction, as appropriate. [**Note**: Further detail in respect of post transaction tasks / milestones will be included in the Post Transaction Integration Plan in due course]
- A programme of due diligence activities has been undertaken with support from the external partner secured to support development of the Strategic Case, Full Business Case and Post Transaction Integration Plan. The legal elements of the due diligence programme of activities has been undertaken by the group's legal advisors. The emerging risks and issues arising from the due diligence programmes were provided to the Group Board in private on 1 September 2026. Draft reports are due to be submitted to the Oversight Group on 12 October 2026 and to the Group Board for approval on 27 April 2026
- Key tasks / milestones in support of the Advanced Foundation Trust (AFT) process will be added to the programme plan in due course. However, the Oversight Group has recommended that whilst AFT status should remain the ambition, the move to a single organisation should remain the focus at the current time
- **Appendix A** on **slide 50** provides the Single Organisation Programme Delivery RAG Rating Matrix

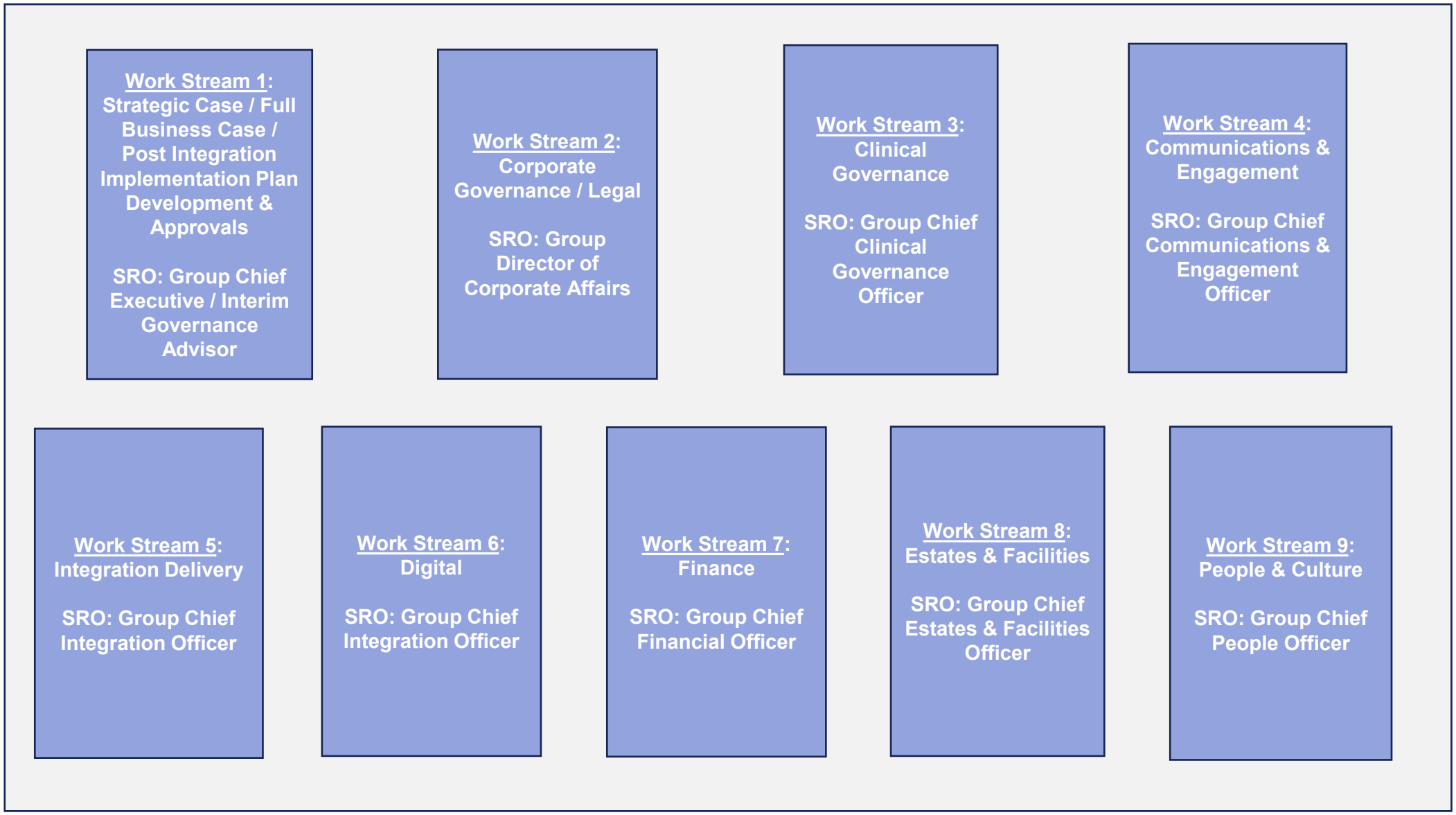
Transaction Timeline Summary

Date	Milestone	Comments
By 31 May 2026	• Agreement of approach to Due Diligence (DD)	• Approach to DD agreed by the Single Organisation Oversight Group on Monday, 11 May 2026 **(Complete)**
	• Approval of Strategic Case (SC) by Group Board	• Extra-ordinary board meeting to take place on Thursday, 21 May 2026 **(Complete)**
	• Submission of final SC to NHSE	• SC to be submitted to NHSE on Friday, 29 May 2026 (31 May 2026 is a Sunday) **(Complete)**
June – July 2026	• Completion of NHSE review of SC and provision of RAG rating to allow the group to proceed to Full Business Case (FBC)	• NHSE review of SC takes 4 – 6 weeks (1 June – 10 July 2026). During this period, there is likely to be a gateway meeting with LCHG, DLN ICB, NHSE, CQC. NHSE RAG rating must be green (minimal support & monitoring) or amber (some areas require further focus) to proceed to FBC stage. Letter to be sent by NHSE outlining position & actions required including any further gateway / checkpoint meetings **(Complete – Amber rating received – approval to proceed to FBC)**
	• Communications & engagement 'Go Live'	• Communications & engagement 'Go Live' scheduled for 12 August 2026 **(Complete) Communications & engagement activities will continue throughout the transaction process**
	• Development of long-term financial modelling of merger costs / benefits	• Modelling templates and support from external partner being provided. Financial modelling to be finalised as part of the development of the FBC **(Underway)**
	• Agreement and commencement of programme of Due Diligence (DD) activities	• Single Organisation Oversight Group to retain oversight of PTIP development and DD activities **(Ongoing)**
	• Development of Post Transaction Integration Plan (PTIP)	• Draft PTIP to be reviewed by the Oversight Group on 12 October 2026 and approved by the Group Board on 27 October 2026 **(Underway)**
July – September 2026	• Completion of DD activities with final report approved by the Group Board	• Emerging risks and issues from DD activities provided to the Group Board on 1 September 2026. Draft DD reports submitted to the Oversight Group on 14 September 2026 and final reports to be submitted to the Group Board on 6 October 2026
	• Development of FBC (to include new Trust name)	• Single Organisation Oversight Group to retain oversight of FBC development **(Ongoing)**

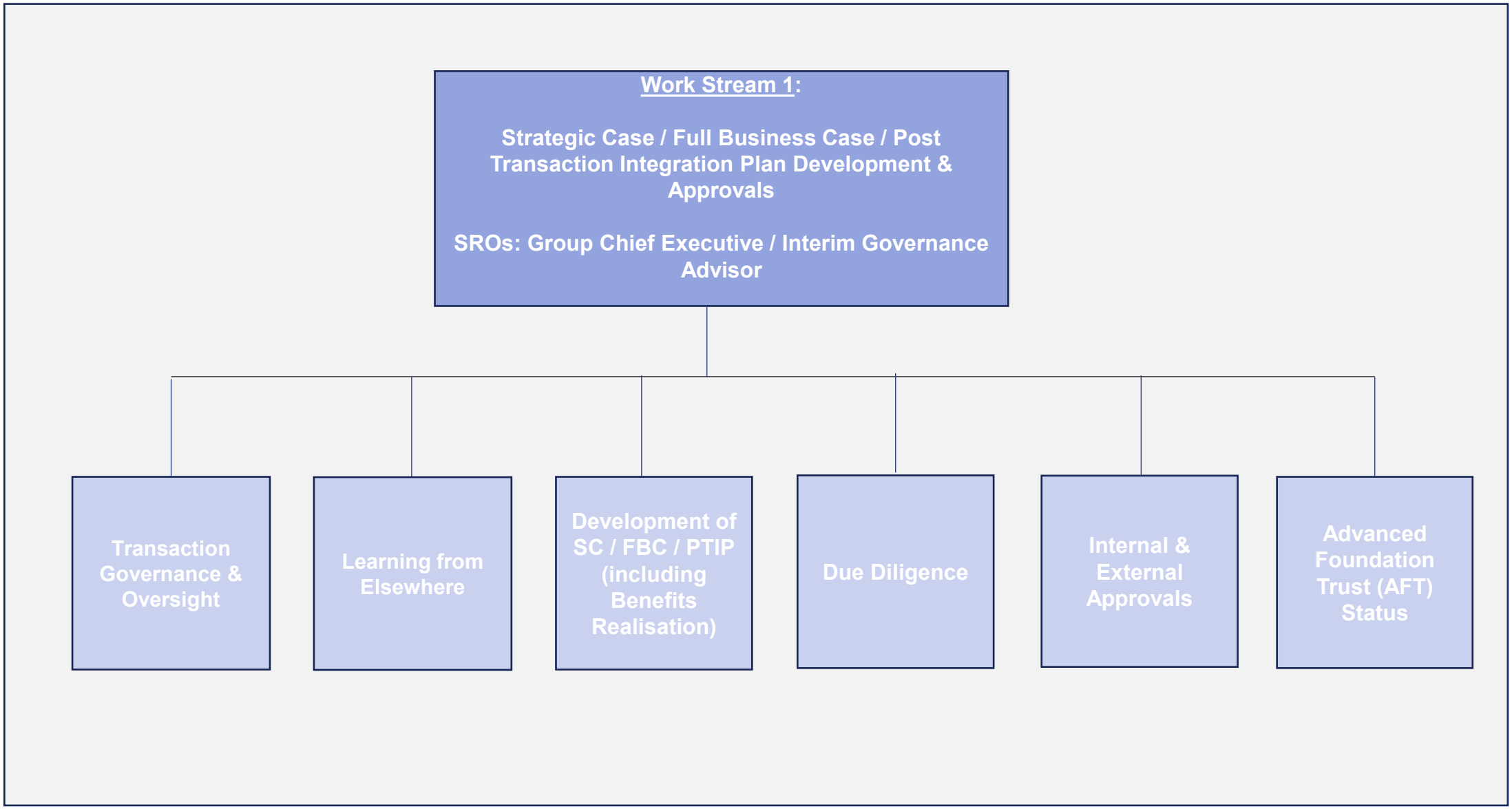
Transaction Timeline Summary cont'd

Date	Milestone	Comments
October 2026	• Completion by NHSE of review of DD outputs • LCHG respond to NHSE DD queries • Approval of FBC and PTIP by Group Board and submission to NHSE	• Single Organisation Oversight Group to retain oversight of DD activities **(Ongoing)** • Group Board approval of FBC and PTIP (including financial modelling, new trust name and DD outputs: risks & mitigations) scheduled for 27 October 2026 • Submission of FBC and PTIP to occur once all milestones are complete (as per NHSE transaction guidance) • Supporting submissions to include board certification and letter of management representation (the latter nearer the date of the transaction)
November 2026 – January 2027	• Completion of NHSE review of FBC and PTIP • LCHG respond to NHSE FBC and PTIP queries • Commencement of TUPE consultation	• NHSE review of FBC and PTIP takes 3-4 months • Gateway meetings with LCHG, ICB, NHSE (may also include CQC), finance & quality governance reviews and completion of (NHSE developed) staff survey also undertaken during this period. The purpose of the staff survey is to inform discussions on staff perceptions of the transaction, culture and readiness for transformational change
March 2027	• Formal approval of transaction by Group Board • Approval of transaction by Secretary of State	• Date for Group Board approval **TBC** • Exact timescales **TBC** and to include the issue of dissolution & transfer orders and the transfer of liabilities
1 April 2027	• Trusts merge	• Subject to approvals and readiness assessment

Single Organisation Programme Plan: Work Streams & SROs



Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 1



Work Stream 1: Strategic Case, Full Business Case & Post Transaction Integration Plan Development & Approvals

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Transaction Governance & Oversight				
Secure Group Board approval to proceed with the transaction process	30 September 2025	Corporate Governance / Legal Communications & Engagement Integration Delivery	**Complete:** Group Board agreed at its September 2025 meeting to proceed with the transaction process and seek the necessary approvals from NHSE	
Initiate dialogue with NHSE	30 October 2025		**Complete:** Discussions held with NHSE who are supportive of the proposed direction of travel. Meeting also held with NHSE national transaction team and guidance received. NHSE representative co-opted on to Single Organisation Oversight Group	
Convene Single Organisation Programme Oversight Group, agree programme work streams & SROs	30 November 2025		**Complete**: Single Organisation Programme Oversight Group convened and being held monthly with reporting to the board through the Group Chair & Group Chief Executive Terms of Reference agreed and approved by the Group Board Initial programme work streams & SROs agreed	
Develop a Single Organisation Programme Plan (planning & delivery)	31 December 2025 **(drafted)** 3 March 2026 **(Group Board approval)**		Programme Plan developed with SROs and approved by the Group Board. Reporting to the Group Board on progress with delivery of agreed programme milestones is through the Group Chair & Group Chief Executive & Oversight Group Upward Report	
Draft transaction risk log	31 March 2027 **(implementation of pre-transaction tasks / milestones)** 1 April 2027 **('Go Live')**		Risk log developed and submitted monthly to the Oversight Group and bi-monthly to the Group Board through the Oversight Group Upward Report. Feedback on the risk log has been provided by the external partner appointed to support development of the Strategic Case, Full Business Case and Post Transaction Integration Plan & incorporated	
Learning from Elsewhere				
Gather intelligence and learning from other organisations who have been through the transaction process	31 March 2027	Communications & Engagement	Intelligence and learning from elsewhere continues to be sourced e.g. North London NHS FT, Company Secretaries Network to inform the group's planning and preparation	

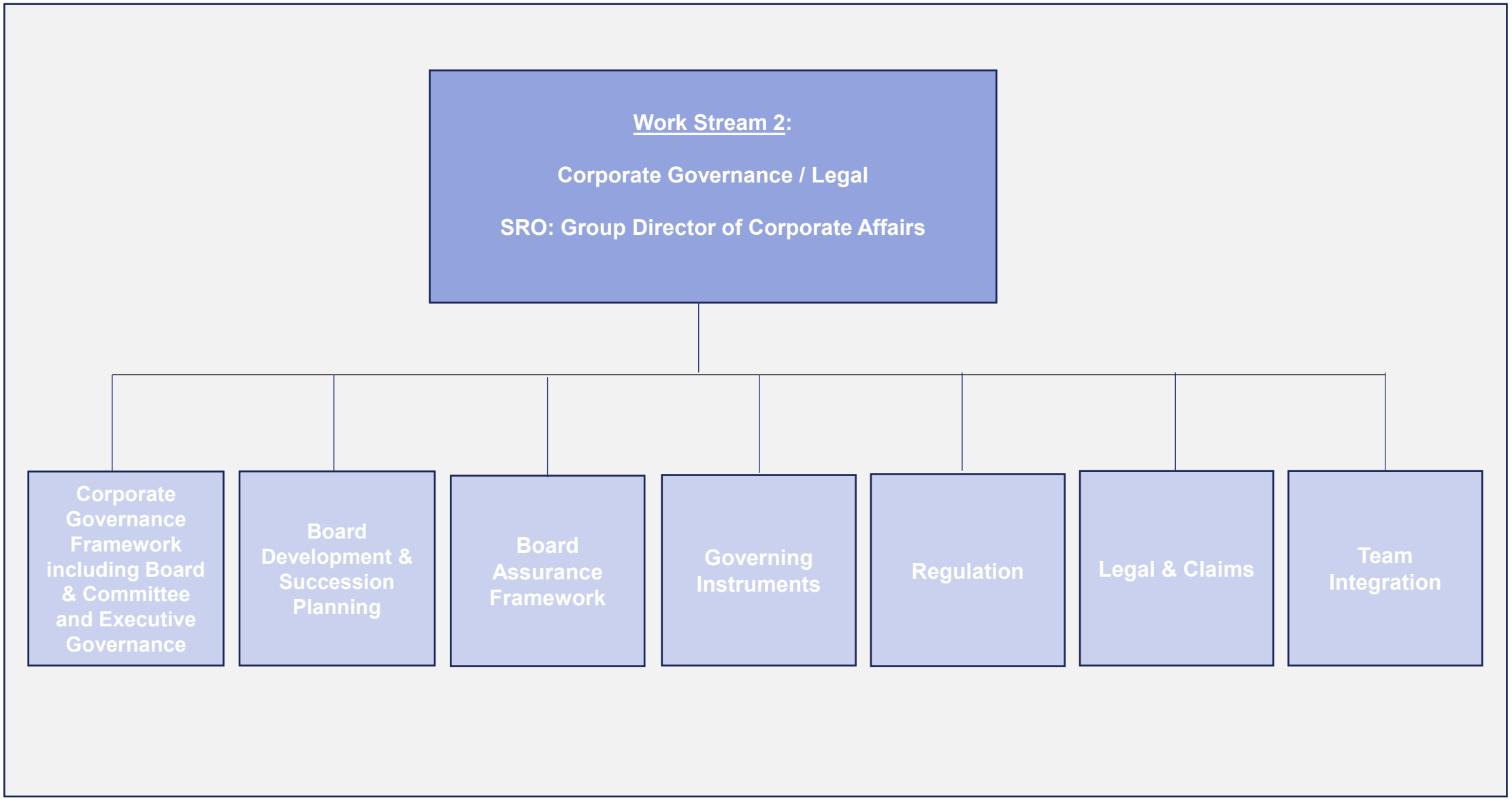
Work Stream 1: Strategic Case, Full Business Case & Post Transaction Integration Plan Development & Approvals cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Development of Strategic Case, Full Business Case & Post Transaction Integration Plan				
Develop Strategic Case (including details of anticipated benefits and how benefits realisation is / will be monitored) and agree timescale for submission to NHSE	21 May 2026 **(Group Board approval prior to submission)** 31 May 2026 **(submission to NHSE)**	Work Streams 1 - 9	**Complete:** Deadline for submission of the Strategic Case to NHSE confirmed. External partner secured to support its development (provision made within 2026/27 financial plan and Group Board & NHSE approval received for this expenditure). Group Board approved the Strategic Case for submission to NHSE on Thursday, 21 May 2026 At the point of submission to NHSE of the Strategic Case, the group will enter the transaction pipeline (timescale for 'Go Live': 1 April 2027)	
Develop Full Business Case and Post Transaction Integration Plan	June – October 2026		Full Business Case and Post Transaction Integration Plan in development: 'on track' for Oversight Group review on 12 October 2026 and approval by the Group Board on 27 October 2026	
Due Diligence				
Agree the programme of due diligence activities to be undertaken as part of the transaction [**Notes:** 1. The purpose of due diligence is to identify areas of risk so that organisations can decide whether to proceed with a transaction and, if so, take action to mitigate these risks as part of integration planning i.e. must be completed early enough in the process 2. NHSE transactions guidance includes a range of due diligence activities (as shown in **Appendix B**) although this is not an exhaustive list. The guidance makes clear that organisations must make their own assessment of the extent of due diligence required	June – July 2026	Work Streams 1 - 9	Programme of due diligence activities agreed by the Single Organisation Programme Oversight Group and undertaken by the external partner sourced to develop the Strategic Case, Full Business Case and Post Transaction Integration Plan The legal elements of due diligence have been undertaken by the group's legal advisors Final Due Diligence reports submitted to the Group Board on 6 October 2026 and outputs: risks & mitigations to be included within the Full Business Case and Post Transaction Integration Plan which are due to be reviewed by the Oversight Group on 12 October 2026 and approved by the Group Board on 27 October 2026	
Reference due diligence findings and how they have been or will be addressed within the Full Business Case and Post Transaction Integration Plan	June – October 2026		To be completed as the Full Business Case and Post Transaction Integration Plan are developed	

Work Stream 1: Strategic Case, Full Business Case & Post Transaction Integration Plan Development & Approvals cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Internal & External Approvals				
Update the internal transaction timeline to include the internal & external approvals and other milestones required for the transaction	31 May 2026 & Ongoing to 31 March 2027	Corporate Governance / Legal	Transaction timeline updated **(slides 3 & 4 refer).** The transaction timeline will remain 'live' and will be updated, as required, as the transaction process progresses	
Schedule the required internal approvals within the board business cycle including: • Strategic Case **(Complete)** • Full Business Case • Post Transaction Integration Plan • Board Certifications • Management Letter of Representation	31 March 2027		Strategic Case approved by the Group Board on 21 May 2026 and submitted to NHSE on 29 May 2026. Approval received for the group proceed to Full Business Case stage	
Advanced Foundation Trust (AFT) Status				
AFT application process to run concurrently with the single organisation transaction process	AFT process 'on hold'	Work Streams 1 – 9	NHSE AFT guidance is out for consultation until 11 January 2026. NHSE will confirm which trusts are eligible to apply [**Note:** Based on the draft guidance referred to above, the two trusts within LCHG currently do not meet the eligibility criteria to apply for AFT status]	AFT 'on hold'
Single Organisation Programme Oversight Group to also have oversight of the AFT application process	30 November 2025 **(Terms of Reference updated and approved)** AFT process 'on hold'		**Complete:** Arrangements in place. Terms of Reference updated to include this requirement and approved by the Group Board	TofR only AFT 'on hold'
All documents developed in respect of the single organisation transaction process e.g. Strategic Case, Full Business Case & Post Transaction Integration Plan to reference the dual ambition of single organisation and AFT status	AFT process 'on hold'		To be completed as the work progresses in respect of the move to a single organisation. AFT process 'on hold'	AFT 'on hold'

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 2



Work Stream 2: Corporate Governance / Legal

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Corporate Governance Framework including Board & Committee and Executive Governance				
Undertake a review of the joint board committees to ensure these arrangements remain 'fit for purpose' in support of the Group Board and the move to a single organisation	~~30 September 2026~~ 31 October 2026	Work Streams 1 – 9	Terms of Reference for review drafted and shared with the Group Chair, Group Chief Executive and Group Director of Corporate Affairs. Review commenced in September 2026 and is due to conclude October 2026 once observations have taken place – timescale amended to reflect	
Complete the review, alignment and embedding of reporting sub-groups	~~30 September 2026~~ 31 October 2026		Ongoing: committee reporting sub-groups have been aligned. Arrangements being embedded and will remain under review to ensure they remain 'fit for purpose' – linked to above review	
Undertake a review of the executive governance meeting arrangements to ensure they remain 'fit for purpose' in support of the move to a single organisation	~~30 September 2026~~ 31 October 2026		To include a review of Terms of Reference + reporting sub-groups and their effectiveness including care group management level meetings	
Embed the use of the new board & committee templates and report writing guidance and implement a programme of report writing training	31 March 2027		Ongoing: templates in place and embedded. Report writing guidance issued. Training aides to be developed, as appropriate, and targeted training to continue to be provided to report authors	
Board Development & Succession Planning				
Agree the Board Development Programme for 2026 / 27 taking account of the planned move to a single organisation	31 March 2026 31 March 2027 **(refresh)**	People & Culture Integration Delivery (Operating Model)	Board Development Programme for 2026 / 27 developed and signed off by Group Chair. Discussions are underway with NHS Providers to provide input into the Board Development Programme, specifically a reflections & preparedness session (i.e. where are we now & readiness for merger & beyond)	
Undertake a board skills assessment to ensure the board retains the appropriate skillset in support of the delivery of the agreed group strategic objectives and the move to a single organisation	31 March 2026 31 March 2027 **(refresh)**		Skills assessment for 2025 / 26 undertaken and new appointments made to the Group Board, as appropriate. Skills assessment framework for 2026 / 27 and beyond in development	
Continue to utilise the Associate NED role to complement the existing NED capacity and skillset and support succession planning	Ongoing		**Complete:** Ongoing	
Undertake a review of the structure and operation of the Group Board to identify any required changes support the transition to a new single trust board that will meet the needs of the new single organisation	31 December 2026 **(review complete)** 1 April 2027 onwards **(implementation)**		Terms of Reference for the review of the board and board committees have been drafted and shared with the Group Chair, Group Chief Executive and Group Director of Corporate Affairs. Review to be forward looking. The Group Chair and Group Chief Executive are also currently reviewing the board structure	
Board Assurance Framework (BAF)				
Continue to refine the BAF: ensuring target risk scores reflect the agreed group risk appetite and that the development of the 2026 / 27 BAF includes a 'heat map'	31 March 2026 1 April 2026 onwards **(changes enacted)**	Clinical Governance: Risk Management / Mitigation	**Complete:** Board Development Session held on 17 March 2026 and changes to further strengthen the BAF agreed and being enacted. Relevant executives support the presentation of and discussion on the BAF at board committees (ensuring ownership of their allocated risks)	

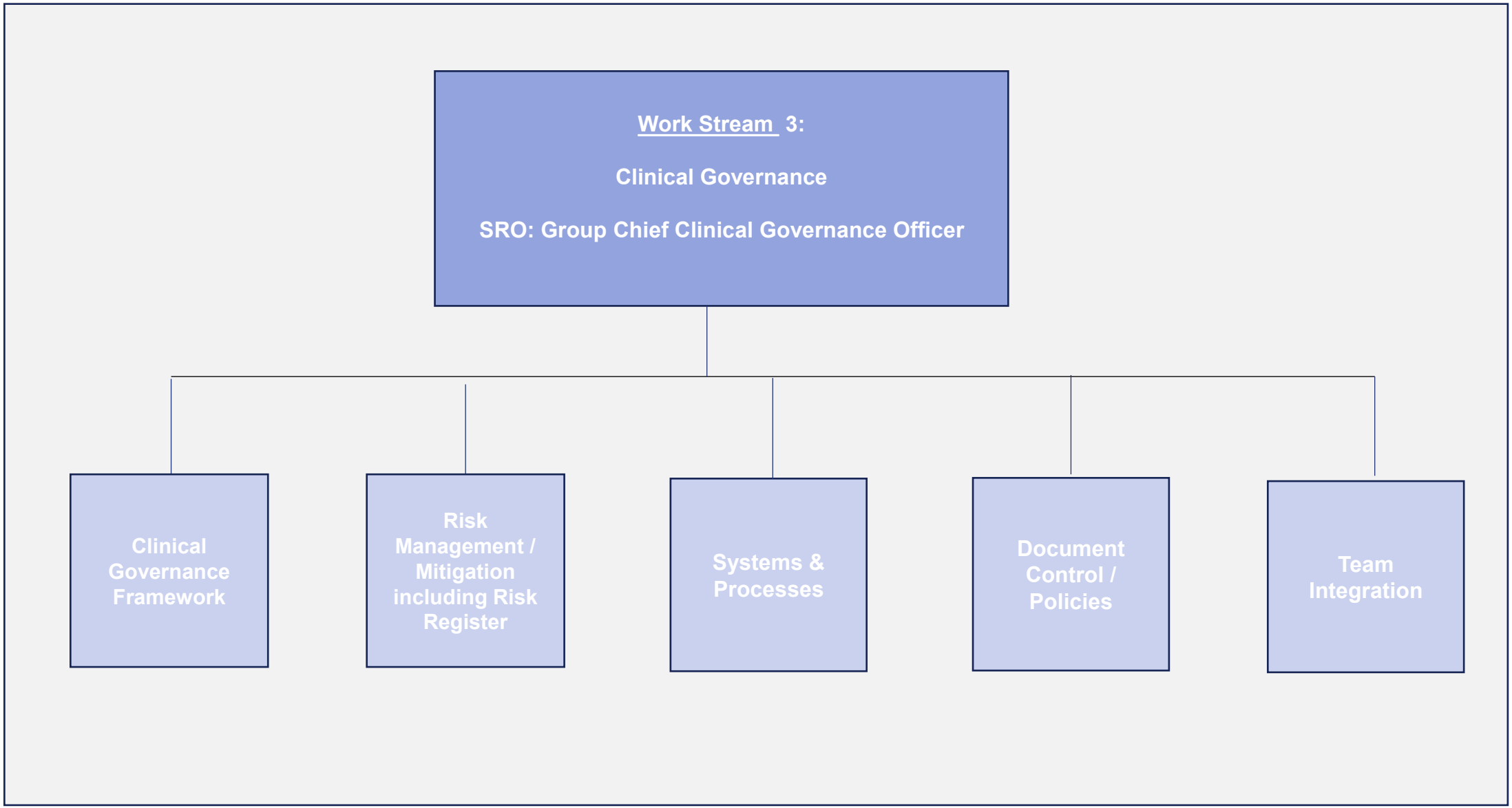
Work Stream 2: Corporate Governance / Legal cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Governing Instruments				
Review, update and approve key documents & governing instruments to reflect the move to a single organisation, new trust name and changes to the operating model to include but not limited to: • Standing Orders (SOs) • Standing Financial Instructions (SFIs) • 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 Person Policy & associated processes	31 March 2027 **(review, updating and approval)** 1 April 2027 onwards **(implementation)**	Work Stream 1	All key governing instruments have been aligned (e.g. SOs / SFIs, Scheme of Delegation) or already created as single group documents (e.g. Performance Management & Accountability Framework, Fit & Proper Person Policy) but will need to be updated post transaction to reflect the new single organisation and any changes to the Operating Model & governance arrangements and to to include the new trust name and visual ID / logo	
Regulatory, Legislative & Other External Requirements				
Move to a single CQC registration	1 April 2027 onwards **(new registration)**	Clinical Governance	Review of guidance being undertaken and agreed process to be followed	
Move to a single ICO registration	1 April 2027 onwards **(new registration)**	Digital	Review of guidance undertaken and agreed process to be followed	
Review the arrangements for the management of charitable funds and the role of the board in a new single organisation as corporate trustee	1 April 2027 **onwards**	Finance	Review of arrangements to be undertaken – any required revised arrangements to be worked up in advance of transaction 'Go Live' Internal Audit provider commissioned to undertake review of current arrangements.	
Move to single trust submissions and declarations e.g. DSPT, provider capability assessment	**1 April 2027 onwards**	Digital	Processes aligned across the group but not yet single submissions and declarations	
Support the transaction process including the scheduling of the appropriate approvals and certifications required in accordance with the NHSE transaction guidance	31 March 2027 **(Strategic Case approved on 21 May 2026)**	Work Stream 1	To be incorporated within the Board Reporting Framework which will also require review as part of the move to a single organisation	
Legal / Claims				
Standardise the claims management arrangements + understanding of how claims will be funded post the move to a single organisation	31 March 2027	Finance	Claims management arrangements standardised across the group. Liaison to occur with NHSR pre and post transaction to include alignment of Panel Solicitors	

Work Stream 2: Corporate Governance / Legal cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Team Integration				
Complete and embed the integration of the corporate governance functions	31 December 2026 **(structure in place)** 31 March 2027 **(structure embedded)**	People & Culture	Restructure underway – consultation document drafted Specific posts to be appointed to in advance of final structure implementation to manage specific risk issues	

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 3



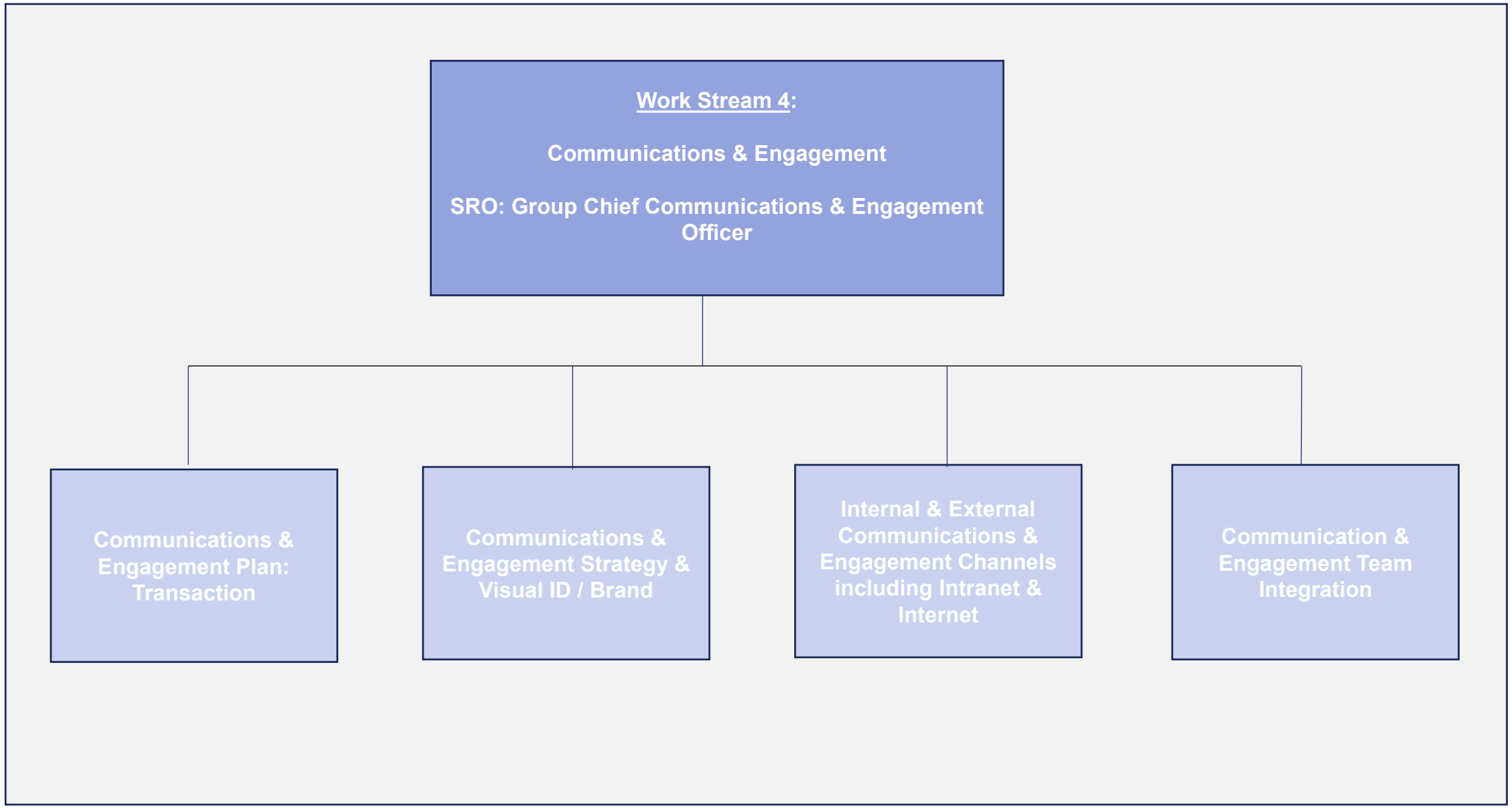
Work Stream 3: Clinical Governance

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Clinical Governance Framework				
Review and refine, as required the clinical governance framework to ensure this remains 'fit for purpose' in support of the move to a single organisation to include a review of the governance arrangements and meetings within Care Groups	30 June 2026 **(review complete)** 30 September 2026 **(revised arrangements in place)** 31 March 2027 **(arrangements embedded)**	Corporate Governance / Legal	Review of clinical governance arrangements undertaken resulting in a revised Group Clinical Governance Directorate and associated policies, procedures and processes. The outstanding area of work was the review of clinical governance arrangements within Care Groups – this is now complete and the Clinical Governance Framework established and presented at GLT in September 2026. The central team are starting to work with the Care groups to review and align reporting structures, standardise templates, roles and responsibilities etc. It is expected that this will be embedded within six months	
Ensure any changes are captured within the Governance Handbook: A Reference Guide for Staff	31 March 2027			Not yet started
Risk Management / Mitigation (including Risk Register)				
Undertake a mapping exercise and consolidate the two separate organisational risk registers into a single combined risk register for the new single organisation (linked to Datix System action below)	31 December 2026 **(new supplier identified)** 31 March 2027 **(changes enacted)** 1 April 2027 **('Go Live')**	Corporate Governance / Legal Datix	The current Datix licences for both Trusts are due to expire at the end of March 2027. Work has commenced on the move to a single system: contract specification issued on the 28 September with an anticipated contract award date of the 27 November 2026. Changes will be enacted between January – March 2027 with 'Go Live' from 1 April 2027	
Ensure the risks within the single risk register are appropriately aligned to the BAF and that these underpinning risks continue to be included within the routine BAF reports to committees and the Group Board	31 March 2026 1 April 2026 onwards **(changes enacted)**		**Complete:** Risks (high level only) from the two separate risk registers are currently captured within the BAF and reports to committees and the Group Board Board Development Session to refresh the BAF for 2026 / 27 held on 17 March 2026 and changes to further strengthen the BAF agreed and being enacted	
Systems & Processes				
Commence a procurement exercise to move to a single Datix (or equivalent) system and contract / licence	31 December 2026 **(new supplier identified)** 31 March 2027 **(changes enacted)** 1 April 2027 **(changes embedded)**	Corporate Governance / Legal	The current Datix licences for both Trusts are due to expire at the end of March 2027. Work has commenced on the move to a single system: contract specification will be issued on the 28 September with an anticipated contract award date of the 27 November 2026. Changes will be enacted between January – March 2027 with 'Go Live' from 1 April 2027. Implementation plan considered at a high level as part of the programme of due diligence activities	
Implement the single Datix (or equivalent) system and the consolidation of incidents, complaints / PAL, claims etc on to the single system				

Work Stream 3: Clinical Governance cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Systems & Processes cont'd				
Undertake a scoping exercise to determine other currently separate subscriptions or licences for other clinical governance systems and processes e.g. national audits, Friends & Family Test	1 February 2027	Corporate Governance / Legal	Processes aligned but separate subscriptions or licences exist for some. The move to a single organisation will facilitate the move to single subscriptions of licences as they come up for renewal	Not yet started
Move to single subscriptions or licences for all clinical governance systems and processes	1 April 2027 onwards		As above	Not yet started
Complete the embedding of other already aligned clinical governance systems & processes e.g. 'Being Fair', Complaints, Learning from Deaths, QIAs	31 December 2026	Corporate Governance / Legal People & Culture	Clinical governance systems & processes already aligned and plan in place to embed. Review to be undertaken at month 9 to ensure these remain 'fit for purpose for the move to a single organisation	
Document Control / Policies				
Agree and implement a harmonised and strengthened approach to document control and policy approvals	30 September 2026	Corporate Governance / Legal	**Complete:** A combined document control policy and process is in place. However, there are plans to strengthen the current system as part of the review of the clinical governance framework to ensure there is a robust long-term solution Gap analysis complete. Improvement trajectory agreed for 2026/27 for bringing remaining out of date policies back into compliance with quarterly reporting to relevant board committees. Improving position seen	
Agree an improvement plan and trajectory for bringing out of date policies back into compliance	28 February 2026 **(agreement of improvement trajectory)** 31 March 2027 **(improvement)**			
Complete the work to align relevant policies & procedures	1 April 2027 onwards		Where relevant, key policies & procedures have already been aligned (or created as single documents) but all policies & procedures will need updating to reflect the new single organisation and to include the new trust visual ID / logo. This will apply across all work streams. Plans to complete this work being considered at a high level as part of the programme of due diligence activities	
Team Integration				
Complete the work to fully integrate the clinical governance functions	Ongoing **(changes embedded)**	People & Culture	**Complete:** New structure being embedded. All current staff members now placed into roles. Any remaining vacancies will be actively recruited to. First Directorate Time Out held	

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 4



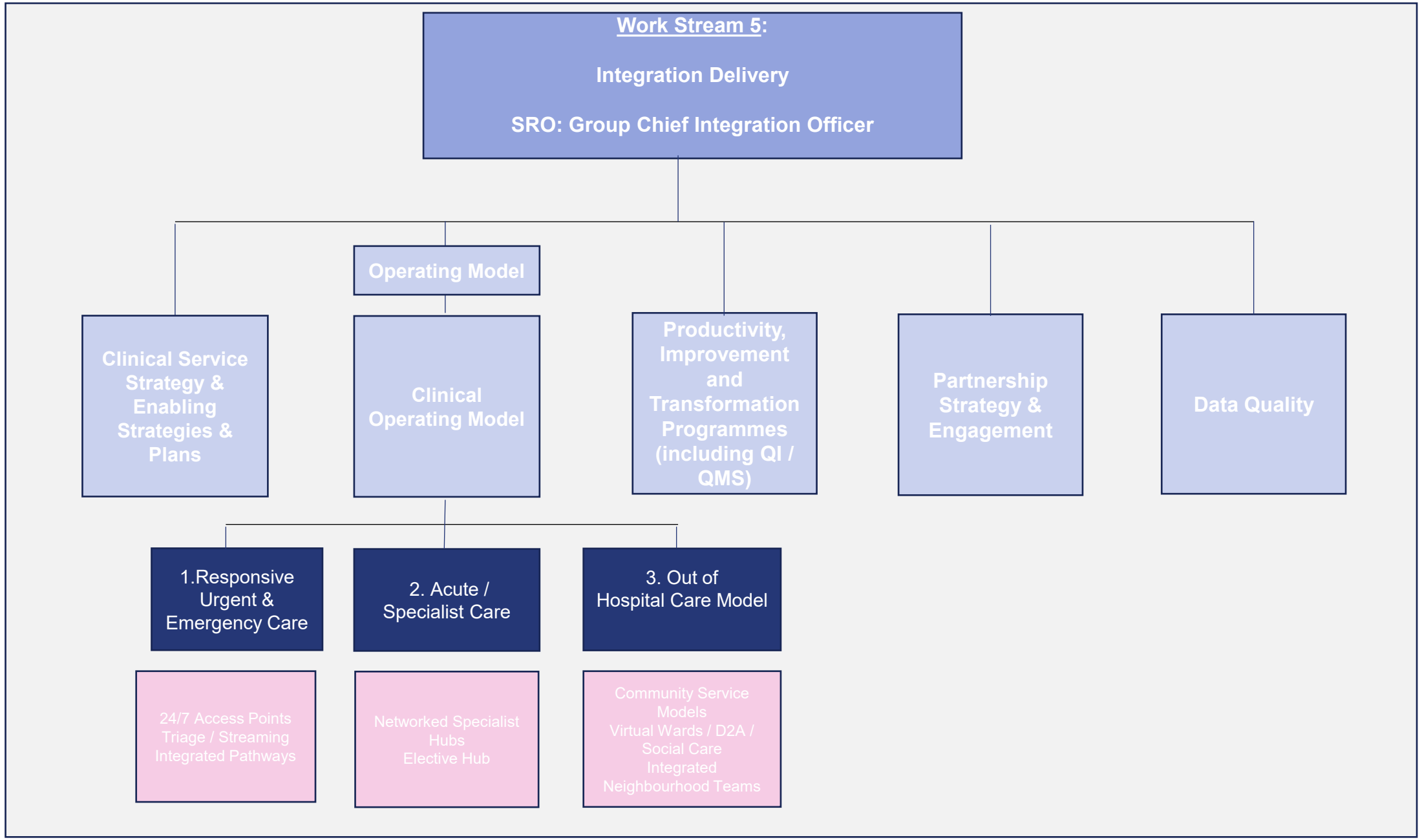
Work Stream 4: Communications & Engagement

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Communications & Engagement Plan: Transaction				
Produce a map of all key stakeholders with whom the group will engage in respect of the move to a single organisation	31 December 2025 **(map & plan drafted)** January & February 2026 **(Oversight Group)** 3 March 2026 **(Group Board approval)** 31 May 2026 **(NHSE submission)** 12 August 2026 **('Go Live')**	Integration Delivery People & Culture (Cultural Integration, Transformation and Engagement Programme)	**Complete:** Communications & Engagement Plan (including Stakeholder Map) & Key Messages drafted and shared with the Single Organisation Oversight Group for comment. Updated versions submitted to the Oversight Group and Group Board in March 2026 Socialising of plans to move to a single organisation to coincide with the development of the Strategic Case. Case studies and Q&As currently being worked up Final Communication & Engagement Plan approved by the Group Board on 21 May 2026 and shared with NHSE as a supporting submission to the Strategic Case. Communications & engagement 'Go Live' scheduled for 12 August 2026	
Develop a Communications & Engagement Plan to support the move to a single organisation which aims to: • provide regular communication and case studies about the work the trusts are currently undertaking jointly and the benefits realised; • communicate, inform and engage proactively with all key internal and external stakeholders about the move to a single organisation and what this will mean for patients / population, staff, the organisations and the wider system				
Communications & Engagement Strategy & Visual ID / Brand				
Develop and publish the LCHG Communications & Engagement Strategy (covering internal communication and staff engagement, external and digital communication, external stakeholder engagement and marketing)	30 June 2026 **(strategy drafted)** 1 September 2026 **(Group Board approval)**	Corporate Governance / Legal People & Culture (Cultural Integration, Transformation and Engagement Programme)	**Complete:** Group Communications & Engagement Strategy drafted and shared at Board Development Session on 21 July 2026. Final version approved by the Group Board on 1 September 2026	
As part of the development of the LCHG Communications & Engagement Strategy, develop a stakeholder map of all key stakeholders and the board / executive leads for managing those relationships (beyond the role of the communications & engagement team)	30 June 2026		**Complete:** Aligned to the single organisation announcement, a stakeholder map with identified executive director relationship owners has been developed. This will be further expanded as part of the implementation of the Group Communication & Engagement Strategy	
Refresh & re-issue the Communications & Engagement Strategy, as required, to reflect the move to a single organisation and change of name	1 April 2027		To be completed to coincide with single organisation 'Go Live' Communications & Engagement Strategy approved by Trust Board – which takes account of being a single organisation. To be reviewed on 'Go Live'	
Develop and agree the visual ID / brand for the new single organisation	1 April 2027		To be completed to coincide with single organisation 'Go Live'	Not yet started
Update the supporting guidance and suite of templates for the use of the new visual ID / brand and change of name	1 April 2027			
Roll-out and socialise the new visual ID / brand and supporting guidance & templates	1 April 2027		To be completed to coincide with single organisation 'Go Live''	Not yet started

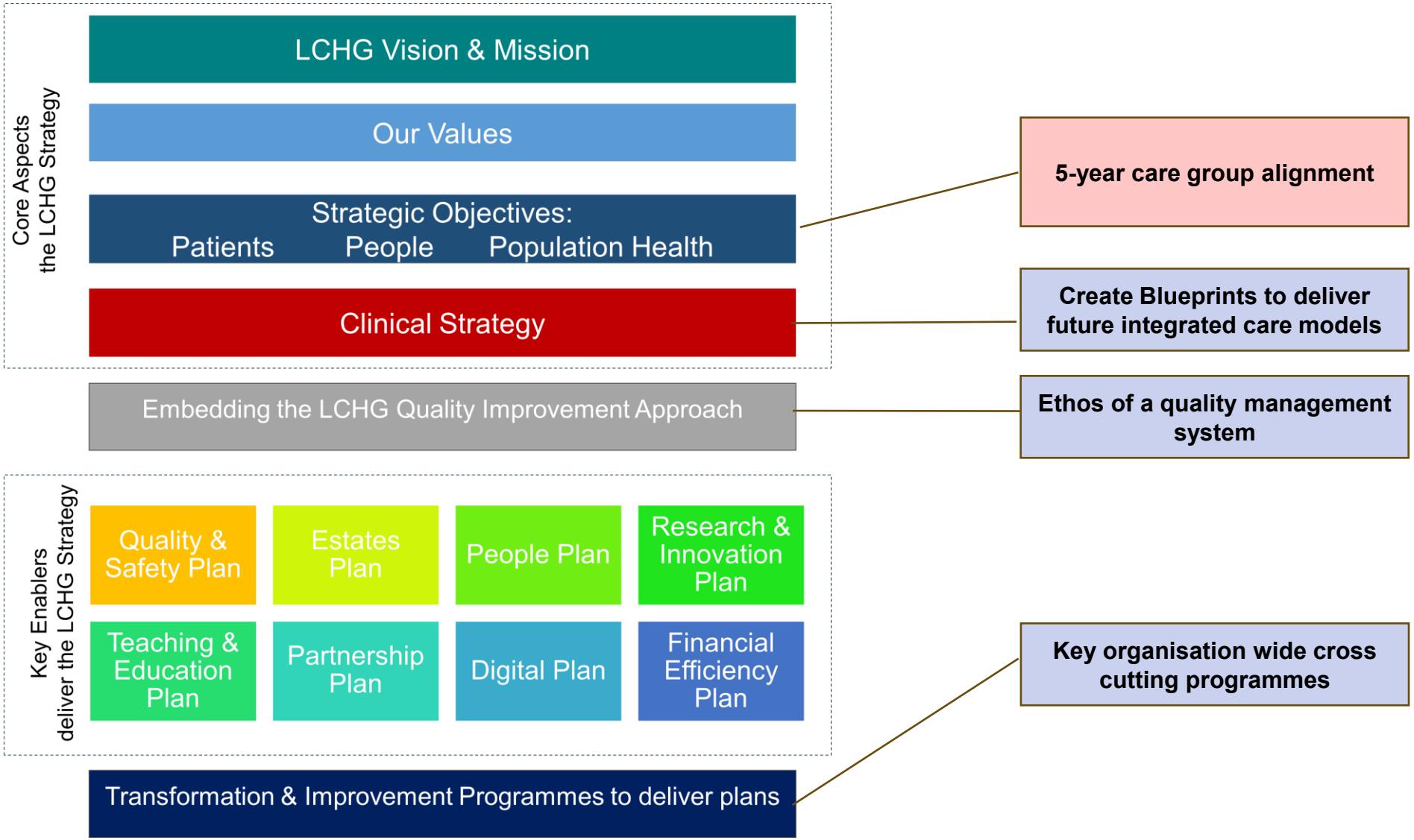
Work Stream 4: Communications & Engagement cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Internal & External Communication Channels				
Create new external facing social media platforms (e.g. Linked-In, Instagram, Facebook, X (formerly known as Twitter) for the single organisation	1 April 2027	Corporate Governance / Legal People & Culture (Cultural Integration, Transformation and Engagement Programme)	To be completed to coincide with single organisation 'Go Live'	Not yet started
Merge the staff closed Facebook group	1 April 2027		To be completed to coincide with single organisation 'Go Live'	Not yet started
Update the internal communications & engagement channels & mechanisms e.g. weekly group bulletin to reflect the new visual ID / brand and change of name	1 April 2027		To be completed to coincide with single organisation 'Go Live'	Not yet started
Update and re-issue the Social Media Policy	1 April 2027		To be completed to coincide with single organisation 'Go Live'	Not yet started
Intranet & Internet				
Update the Intranet to reflect the move to a single organisation and change of name	1 April 2027		Single Group Intranet developed and in place. Updates to reflect the new trust name and visual ID / brand to be completed to coincide with single organisation 'Go Live' of 1 April 2027	
Create a single URL website for the new single organisation which meets accessibility legislation requirements	31 March 2027 **(creation of single website in shadow form)** 1 April 2027 **('Go Live')**	Corporate Governance / Legal	Case of need drafted and funding secured for the creation of a single URL website. Website currently in development and content migration plan is being enacted in readiness for a 1 April 2027 'Go Live'	
Communications & Engagement Team Integration				
Complete the work to fully integrate the communications & engagement function	30 September 2026	People & Culture	The teams are aligned currently but restructure underway. Future structure has been developed with an associated business case for CRIG. New Head of Internal Comms &Engagement post currently under recruitment.	
Continue to provide communications & engagement support to the transaction programme plan and work streams, as required	Ongoing		Staff engagement in respect of cultural integration will require greater focus and investment: plan in place. Dedicated communication plan to be developed specifically related to TUPE of staff	

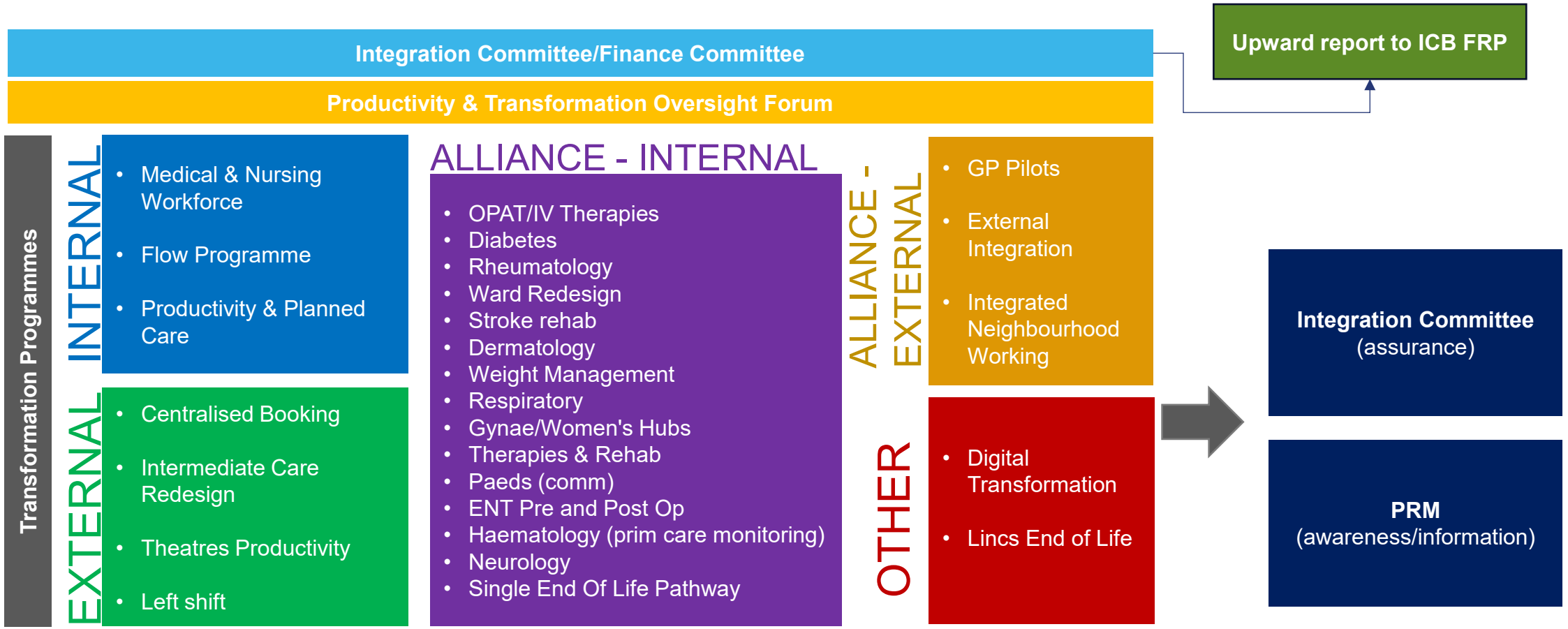
Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 5



LCHG Strategy 2025-2030



LCHG Productivity & Transformation Programmes



On going work on alignment of key programmes and reporting

Work Stream 5: Integration Delivery

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Clinical Service Strategy & Enabling Strategies / Plans				
Develop and approve the Clinical Strategy and formalise the timetable for the development of the underpinning enabling strategies & plans in support of delivery and embedding of the overall Group Strategy	31 July 2026 **(strategy drafted)** 1 September 2026 **(Group Board approval)**	Work Streams 1 – 9	**Complete:** Clinical Service Strategy finalised and reviewed by the Integration Committee in July 2026 and approved by the Group Board on 1 September 2026. The key enabling plans required to deliver the LCHG strategy and a timeline for their development has been agreed	

Monitor delivery of the group and clinical strategy and enabling plans including (patient) benefits realisation	Ongoing		**Complete & Ongoing:** LCHG strategy delivery is monitored through various forums as follows:
			• Care Group Annual Plans
			• Quarterly LCHG strategy delivery reports to the Group Board. The delivery report is triangulated against quantitative KPIs from the Integrated Performance Report and BAF
			• Qualitative measures reviewed at board committees include:
			  ○ Patient stories
			  ○ Clinical narratives
			  ○ Staff feedback: QI huddle themes; pulse surveys; Freedom to Speak Up insights.
			  ○ Stakeholder engagement
			  ○ Service user panels
			  ○ Learning summaries
			• Operational delivery alongside benefits realisation of key transformation programmes is monitored through the Productivity, Improvement and Transformation Oversight Forum	

Build and embed a new integrated strategy, planning, improvement and re-design team and ensure alignment of the team to support delivery of the LCHG strategy	30 April 2027	People & Culture	**Complete** The Strategy, Improvement and Redesign Team has been fully established, with all roles recruited to and embedded. The team is now operational and supporting organisational priorities. Culture, competency and capability development will continue as part of an ongoing programme of organisational development and continuous improvement	

Work Stream 5: Integration Delivery cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Operating Model (including Clinical Operating Model)				
Review and refine the group operating model (including clinical operating model) and associated leadership arrangements to ensure these arrangements remain fit for purpose in support of the move to a single organisation and ensuring that clinical leadership remains central to the operating model	31 October 2026 **(review complete)**	Corporate Governance / Legal	**Complete:** Review complete and draft structures developed.	
	1 April 2027 onwards **(implementation)**		To be completed prior to transition to the new single organisation –	
Complete the work to align and consolidate the group support service infrastructure and associated policies, processes and arrangements in support of the refreshed operating model	Ongoing	Work Streams 1 – 9	See separate work streams	
Productivity, Improvement & Transformation Programmes (including QI / QMS)				
Deliver agreed productivity improvement & transformation programmes	31 March 2026 31 March 2027	Corporate Governance / Legal	**Complete:** Productivity, improvement & transformation programmes agreed and monitored through the Integration Committee	
Undertake a scoping exercise to identify all existing Quality Management Systems (QMS) across the group and agree the preferred option	30 September 2026	Clinical Governance People & Culture	Scope to be agreed	
Develop a Group Quality Improvement (QI) Plan and commence implementation of agreed QMS as a key enabler to delivery of the agreed productivity, improvement & 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)**		**Complete:** QI Strategy approved at Integration Committee and Group Board Development Session in March 2026. Progress update on QI development plan at Integration Committee in November 2026	
	31 December 2026 **(QMS)**		QMS implementation plan in development	

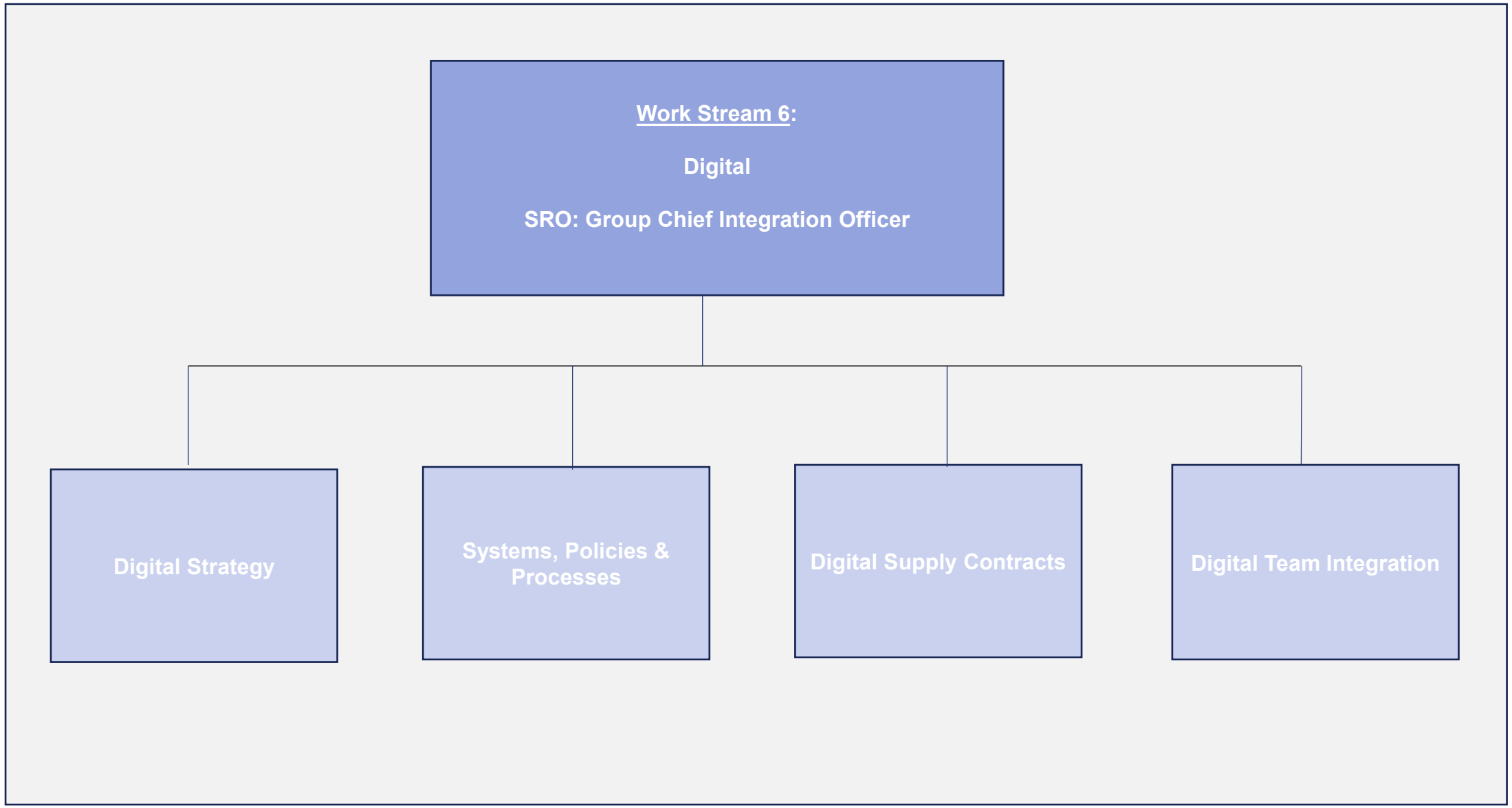
Work Stream 5: Integration Delivery cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Partnership Strategy & Engagement				
Develop a Partnership & Engagement Strategy	30 April 2026	Communications & Engagement	**Complete:** The Partnership & Engagement Strategy for the group has been developed and refreshed in line with the group strategy and the creation of an Alliance Model and includes: • Development of a Partnership Plan and Delivery Plan for 2026-30 to bring it back into alignment with the LCHG 5-year Strategy • Refresh of the Delivery Plan in each of the four years to allow us to develop the detail and respond to what is likely to be continued volatility and uncertainty • Incorporation of the updated stakeholder mapping work requested by LCHG Board • Better alignment with the new enabling plans in development for 2026/27. • Clarification of the accountability for delivering partnerships within the Group performance management and accountability framework and executive portfolios The Partnership & Engagement Strategy was approved by the Integration Committee in April 2026 and Group Board on Tuesday, 5 May 2026	

Work Stream 5: Integration Delivery cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Data Quality				
Develop and implement a Data Strategy which seeks to improve data maturity, literacy and accuracy and which aligns with the wider Digital Strategy	31 July 2026	Digital	**Complete:** Data Quality 'skeleton' plan developed and considered by the Finance & Performance Committee. Final Data Quality Plan approved by the Finance & Performance Committee in July 2026	
Design, approve and implement a Performance Management & Accountability Framework 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, care group & 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'	**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 March 2026		**Complete:** Group Performance Management & Accountability Framework approved and aligned PRMs in place. The Group Accountability & Performance Management Framework will be updated in due course to reflect the move to a single organisation The alignment of the IPR is now complete but needs embedding: new style performance reports for board committees are now 'live' and are going through their 3rd cycle with metrics having been agreed with committee chairs and relevant Executive SROs. These new style reports replace the old performance reports and will focus on areas of under performance The first amalgamated IPR has been submitted to the Group Board The new style reports will continue to be refined and embedded over the coming months	
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'	31 March 2026		**Complete:** New performance information system developed and deployed (RACH). RACH also being deployed to support PRMs and the IPR for board	
Complete the work to fully integrate the performance team	31 December 2026		Integrated structure drafted and budget confirmed. Advert for Director of Performance to be in post by the end of July 2026. Consultation on new structure to commence thereafter	

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 6



Work Stream 6: Digital

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Deliver the Digital Strategy with a focus on digital integration, transformation and new ways of working to include the following specific actions / milestones:	Ongoing	Corporate Governance / Legal Communications & Engagement	**Complete:** Digital Strategy in place and work to align the digital infrastructure, systems, policies & processes is well underway	
• complete the alignment of the digital systems in place across the group in accordance with the digital system alignment plan and where feasible to do so;	Ongoing		Digital system alignment plan largely complete. Priority systems (ESR, Health Roster, Datix, Finance etc.) have been identified for digital to support work post merger. Some limitations due to existing contracts and sovereignty requirements e.g. finance, ESR. The move to a single organisation will remove sovereignty restrictions and support alignment of remaining systems and provide a more simplified digital experience for staff. There will be further work required post to align contracts to the new organisation name	
• 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;	1 November 2025 **(AGEM transition to LCHG)** 31 January 2026 **(delivery of programme plan)**		**Complete:** While the scope of this work has changed significantly since the commencement, digital support services for LCHS, ICB Corporate and primary care (GPIT) moved to group working successfully from 1 November 2025. During the period of work the CSU closure programme was announced and LCHG is working with system partners including LPFT to prioritise work required to ensure a safe transition from CSU supported infrastructure Digital support service provided to LPFT who transitioned successfully from 8 June 2026	
	31 July 2027 **(full implementation)**		A programme of work needs to be stood up to bring LCHS employed users and devices into the current ULTH domain. The options appraisal is prepared and will need to go through the appropriate governance route (Digital Oversight Group > Integration Committee). Single domain has been identified as a key enabler to be delivered as soon as possible following the merger, including outline costs and timelines within the PTIP. While preparatory work can take place this is post merger activity. With funding approval with the business case this is expected to be delivered in full within 1 year of merger	

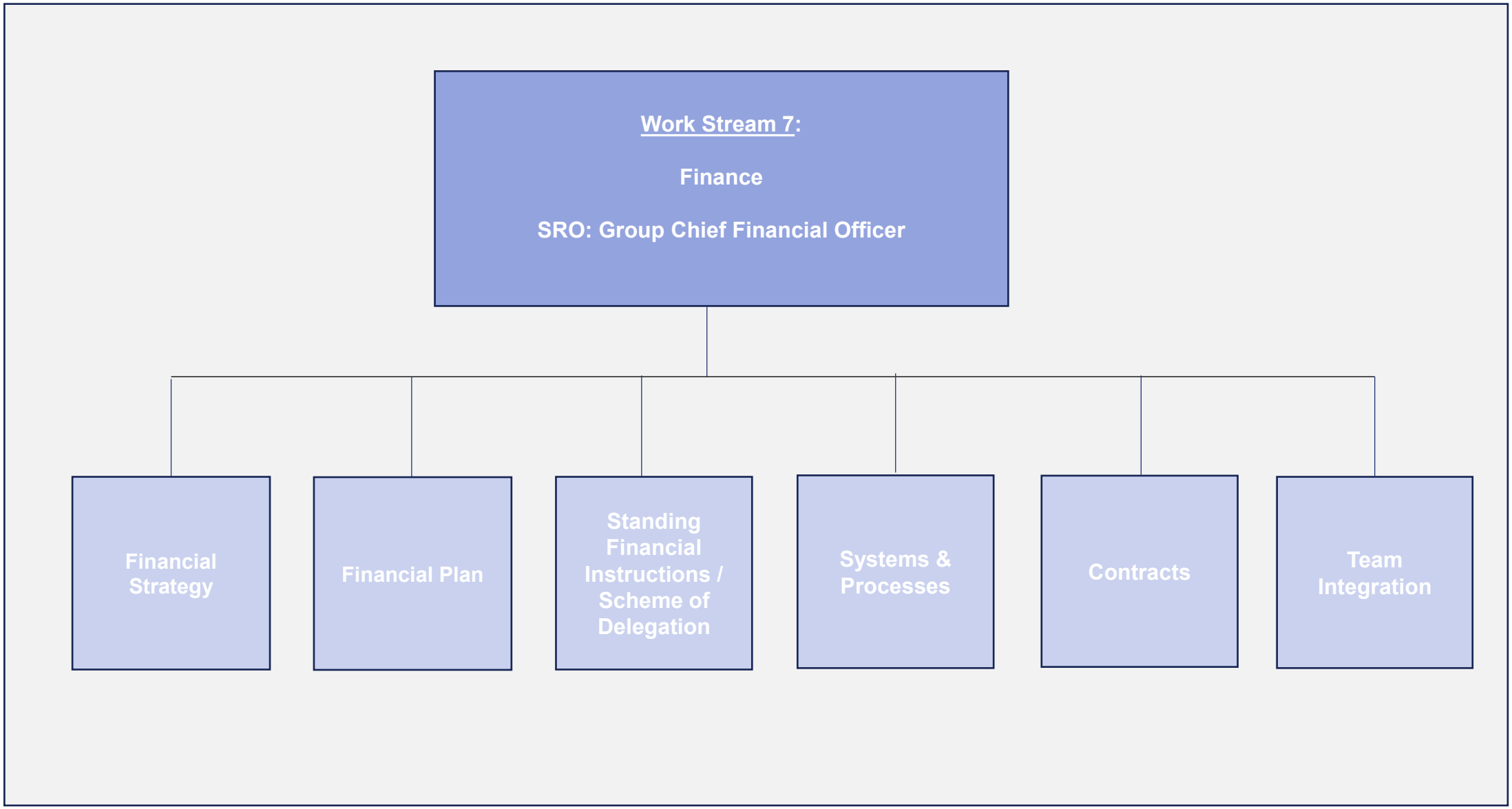
Work Stream 5: Integration Delivery – Digital cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
• move to standardised printing & print codes;	31 March 2026 **(procurement outcome)**	Corporate Governance / Legal Communications & Engagement	**Complete:** Pre-market engagement took place during December 2025 as part of the procurement process. Full replacement aligned to contract end dates: ULTH: July 2026 and LCHS: April 2027	
	30 September 2027 **(full implementation)**		Interim work arounds in place. While full implementation is planned for September 2027, discussion has already taken place with potential suppliers to determine how benefits can be delivered earlier	
• undertake a review of and align all digital supply contracts;	30 June 2027		Where possible, digital supply contracts have been aligned for priority systems. Some limitations due to existing contracts and sovereignty requirements. Whilst a sizable piece of work to align all contracts, the move to a single organisation will enable all supply contracts to be aligned	
• complete the work to align all digital policies & processes	31 January 2026 **(M365 approach)** 30 September 2026 **(digital policies)**		**Complete:** Digital policies refreshed to support the requirements of the Cyber Assessment Framework (CAF) and aligned Data Security and Protection Toolkit (DSPT). Group Digital policies tabled at the Information Governance Group in September 2026. This approach supports the requirement of the merged organisation and overall simplified approach across LCHG and reflects 26/27 CAF DSPT requirements.	
• complete the work to align and embed the digital teams	Ongoing		**Complete:** Digital teams now integrated and being embedded under the Director of Digital. The Director of Digital has oversight of digital capacity & capability The Digital services management of change process (consultation) concluded in December 2025 and the management roles and structure are now in place	

Work Stream 5: Integration Delivery – Digital cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
The group should consider how it can improve the profile of digital and amplify its voice at Group Board and committee level	30 June 2026	Corporate Governance / Legal Communications & Engagement	**Complete:** The Group Director of Integration is the executive director with board level responsibility for Digital. There is reporting to the Group Board on relevant aspects of the digital agenda through the Finance & Performance and Integration Committees Upward Reports and through board development sessions Digital updates are also provided to GLT by the Director of Digital who is also now a member of GLT	

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 7



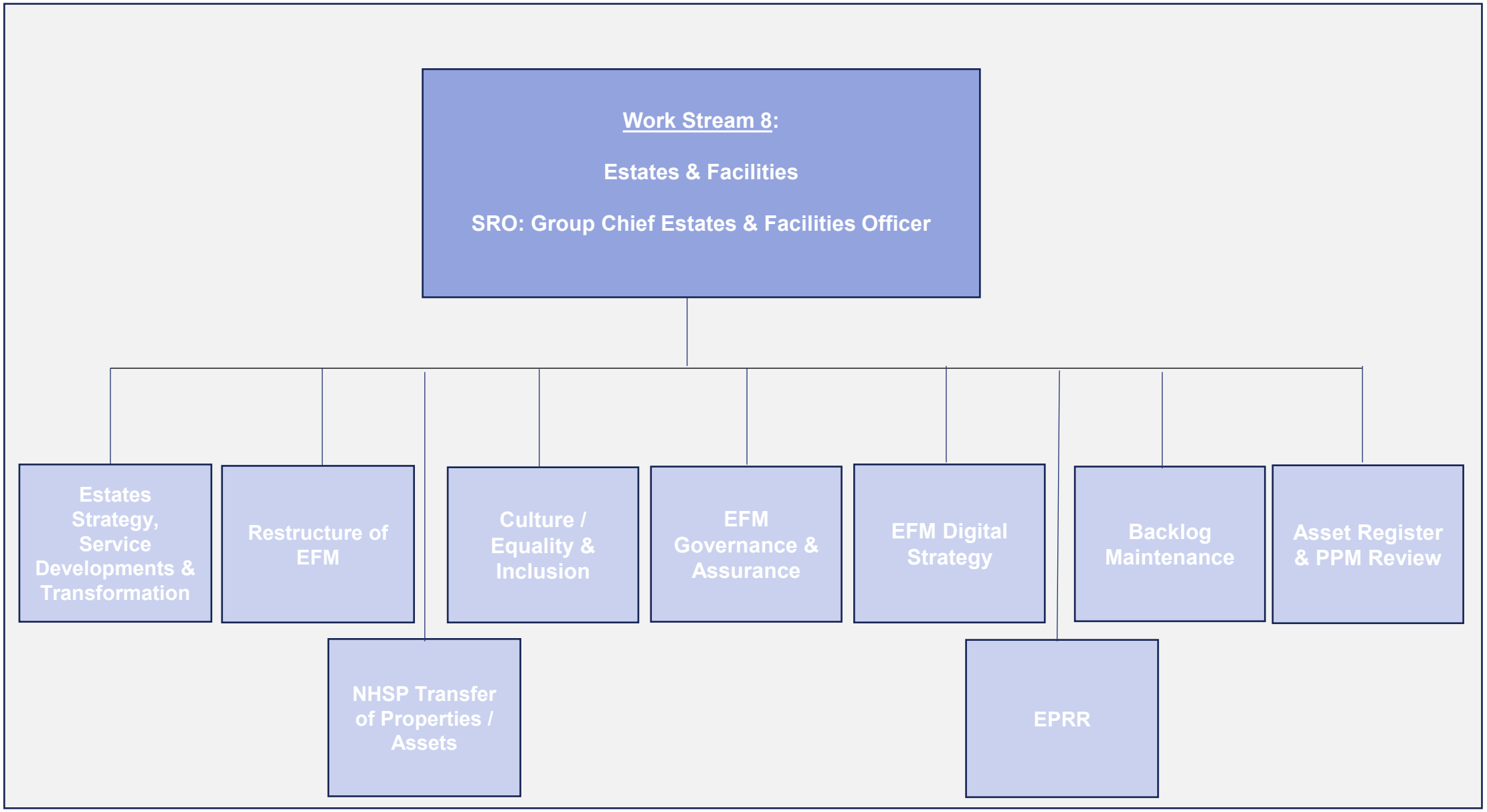
Work Stream 7: Finance

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Financial Strategy				
Develop a Finance Strategy in support of delivery of the agreed group strategic aims & objectives	1 July 2025 **(strategy drafted)** 3 March 2026 **(Group Board)**	Corporate Governance / Legal	**Complete:** Strategy developed and approved by the Finance & Performance Committee in December 2025 and submitted to the Group Board in March 2026	
Financial Plan				
Develop a medium to long term financial plan / model in support of the group's merger application including financial benefits and costs of the transaction	30 June 2026 **(financial plan)** 31 October 2026 **(financial modelling: costs / benefits)**	Corporate Governance / Legal	**Complete:** Two-year financial plan developed as part of 2026 / 27 planning submission. Plan extended to five years based on high level assumptions alongside known changes and taken through the Finance & Performance Committee in July 2026 Financial modelling on the costs / benefits of the transaction being finalised as part of the development and submission of the FBC. Current position is output is likely to shore up 27/28 efficiency programme rather than providing additional savings above CIP level	
Continue to deliver financial efficiencies and productivity improvements	Ongoing	Integration Delivery	Financial efficiencies and productivity, improvement & transformation programmes agreed and monitored through the Finance & Performance Committee, Integration Committee and Group Board	
Align and strengthen financial reporting	Ongoing	Corporate Governance / Legal	Financial reporting is now consistent across the group. Finance information dashboard is being strengthened. Work continues to improve the flow of financial reporting. Work started on combined reporting for April 2027	
Standing Financial Instructions (SFIs) / Scheme of Delegation & Powers Reserved to the Board				
Develop a single set of SFIs / Scheme of Delegation & Powers Reserved to the Board to reflect the move to a single organisation	31 March 2027 **(review updating & approval)** 1 April 2027 **(implementation)**	Corporate Governance / Legal	SFIs and Scheme of Delegation have been aligned to reflect the move to group but will need developing into a single form for the new organisation in due course	Not yet started
Policies, Systems & Processes				
Complete the work to align and embed financial policies & processes / controls	31 March 2027	Corporate Governance / Legal	Financial policies aligned and up to date. Finance processes / controls aligned. Work is also underway to update and strengthen business continuity plans and to ensure consistent ways of working	
Undertake a mapping exercise and consolidate the two existing finance ledgers into a single ledger and contract	31 March 2026 1 April 2027 onwards **(single contract)**		Ledger supplier aligned across the two trusts. Review of ledger differences underway to understand scale of challenge. Review of hierarchies and approval flows also being undertaken. The move to a single contract will be progressed to coincide with the move to a single organisation	

Work Stream 7: Finance

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Contracts				
Undertake a review of and align all key commercial contracts / agreements	1 April 2027 onwards	Corporate Governance / Legal	Key contracts / agreements aligned but will need re-issue once the group moves to a single organisation and new name Internal Audit are undertaking a review of the group's commercial contract management arrangements which will help inform best practice	
Move to a single internal audit contract	1 April 2027		Internal audit arrangements have been aligned. The move to a single organisation will necessitate / enable the move to a single contract	Not yet started
Move to a single external audit contract	1 April 2027		External audit arrangements have been aligned. The move to a single organisation will necessitate / enable the move to a single contract	Not yet started
Team Integration				
Complete the work to integrate the finance & procurement teams	Ongoing	People & Culture	Teams aligned and arrangements continue to be embedded. Work underway on team structures: senior team structure currently being implemented and sub-team structure being developed. Consultation anticipated October / November 2026	

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 8



Work Stream 8: Estates & Facilities

Key Tasks / Milestones	Timescales	Interdependencies	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 August 2026 **(strategy drafted)** 6 October 2026 **(Group Board approval)**	Integration Delivery: Clinical Strategy	Estates Strategy under development and will be finalised once the new Group Clinical Strategy is finalised and approved. Draft Strategy delayed due to technical issues with the development control plan (now resolved – revised timescale for completion proposed)	
• 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	Ongoing		Assessment of options undertaken - wholly owned subsidiary is no longer an option being considered in light of new national guidance. Further guidance expected from NHS Property Services. Existing EFM service delivery model remains in place and ongoing.	
• 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	31 March 2027		Space remains at a premium across the group This remains an ongoing 'live' piece of work which will inform the Estates Strategy and will require collective input and support from ELT when agreeing priorities for the utilisation of space	
• continue the programme of ward refurbishments, as funding is available	Ongoing		No dedicated funding currently available although the group continues to successfully bid against specific external funding allocations e.g. maternity theatres Competing and often more urgent priorities means that ward refurbishment is not always the priority within the capital programme. This will remain under review	
• undertake a review of all leases and licences across the group	1 April 2027 onwards		Review complete Leases and licences will be re-negotiated and issued once the group moves to a single organisation and new name and as they come up for review	
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 December 2026	People & Culture	This remains an ongoing piece of work which is linked to the planned culture work within EFM and the development of an EFM 'Accountability Framework'. Restructure underway, with outstanding HR issues resolved. JNF approval sought in September 2026	

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

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Culture / Equality & Inclusion				
Re-set the culture within EFM including expectations in respect of performance and behaviours and develop an EFM 'Accountability Framework;	31 March 2027	People & Culture	**Complete:** Culture workshop launched and plan developed for 2026/27	
Continue to promote equality & inclusion and reduce workforce inequalities within EFM:	31 March 2027		Ongoing	
• develop a single approach to the movement of EFM staff across the group	31 March 2027		Ongoing	
• align and improve the processes for staff development, on boarding etc. across EFM	31 March 2027		Ongoing	
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:	31 March 2026 **(PPM audit complete and report received)** 30 September 2026 **(follow-up review completed)** 9 October 2026 **(report)**	Corporate Governance Clinical Governance: Document Control / Policies	EFM Head of Compliance recruited and structure & processes operational. Health & Safety Committee & Safety Groups in place. Arising from a recent PPM audit, the Group Chief Estates & Facilities Officer has now commissioned an independent follow-up review of the implementation of recommendations from previous EFM reviews e.g. LST, Water Safety etc., to provide assurance as to the robustness of relevant EFM governance & assurance processes. Terms of Reference finalised and review commenced	
• 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	31 August 2026		**Complete:** Process for the completion and submission of the PAM aligned. The above-mentioned review will consider the robustness of processes for monitoring delivery of agreed PAM improvement actions	
• undertake a review of Approved Persons (APs) for the relevant HTMs and as a key element of the EFM governance & assurance processes. Move to single AE contracts as appropriate part of the move to a single organisation	31 March 2027		AEs in place. Gaps in community covered by NHPS. These arrangements and the effectiveness of AE support will remain under review – central AE register / checks being set up nationally. Also linked to the work on the transfer of properties from NHPS to trusts. Arrangements being reviewed as part of the single organisation diligence process – information provided	
• review, update and align the EFM policies and procedures across the group	31 March 2027		Review of EFM policies & procedures is underway: Fire Policy & Health & Safety Policies aligned	
• Develop and EFM Document Control Policy & Procedure which is aligned to the wider Group Document Control Policy & Procure	31 March 2027		Linked to the outcome of the PPM audit	

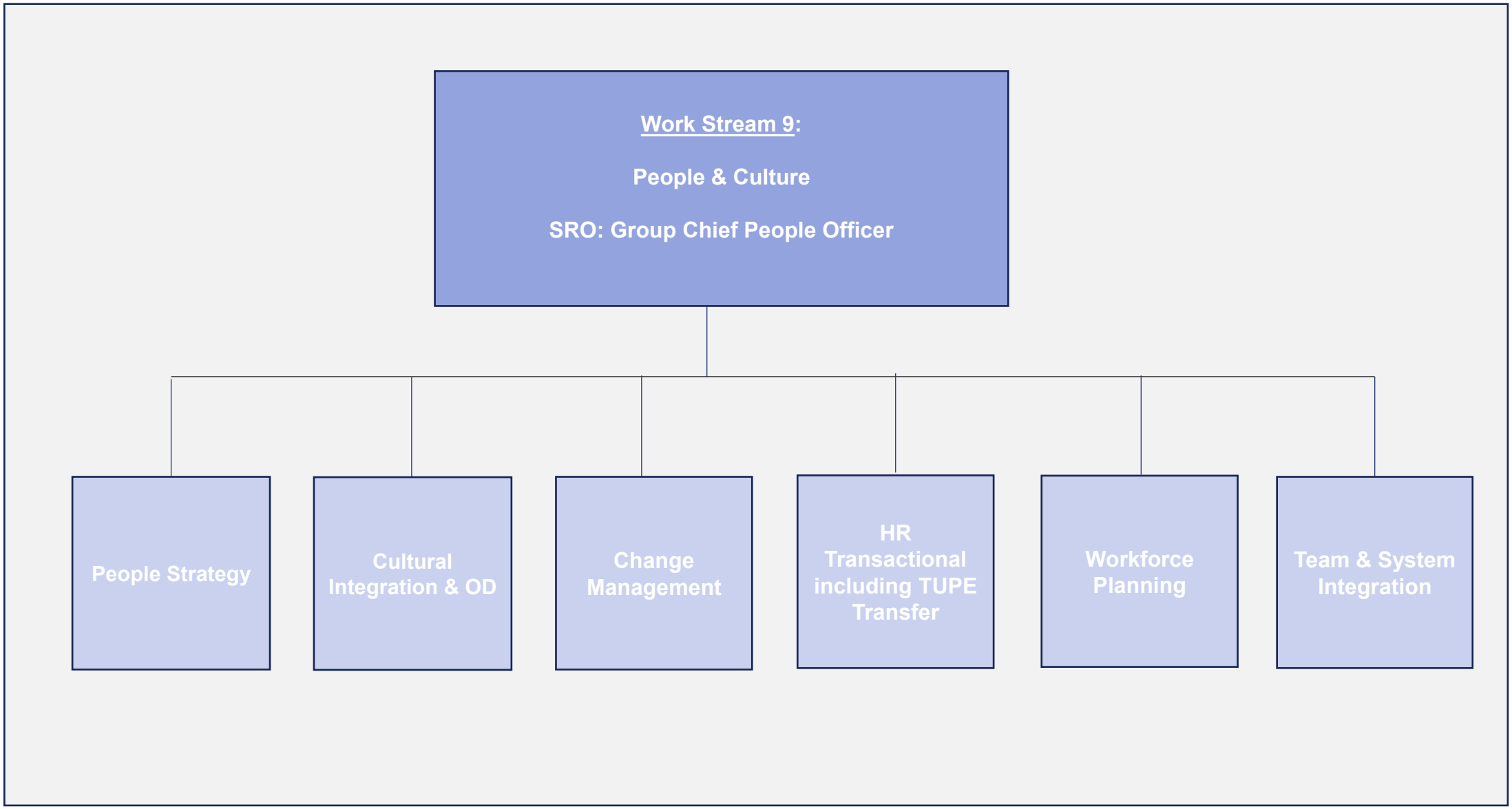
Work Stream 8: Estates & Facilities (cont'd)

Key Tasks / Milestones	Timescales	Interdependencies	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	31 March 2027	**Digital**	Digital strategy for EFM to be developed aligned to the wider Group Digital Strategy to include the implementation of a single service desk approach and reflecting recommendations from the recent PPM audit. Work on this has now commenced.	
Backlog Maintenance				
Continue to review the findings of the six-facet survey and identify critical estate infrastructure risks (CIR) across the group	Ongoing	Clinical Governance: Risk Finance	Ongoing as part of 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		**Complete for 2025 / 26:** 7.1m ICB monies received. £2.9m allocated internally. Funding being used to address priority areas: fire alarm and HV system at Pilgrim Hospital	
• ensure CIR risks are addressed in respect of any new developments across the sites	Ongoing		Capital design team to ensure backlog maintenance items are included as part of the brief in any new build capital developments	
• provide regular backlog maintenance progress reports to the Finance & Performance Committee and Capital & Revenue Investment Group	Ongoing		**Complete:** Reporting in place and ongoing as part of BAU	
• ensure all CIR risks are recorded on the trusts' risk registers	Ongoing		**Complete:** CIR risks added to the risk register. This remains an ongoing process as part of BAU	
Group Asset Register & Planned Preventative Maintenance (PPM) Review				
Review the group assets and ensure a comprehensive and accurate asset register is created	31 March 2027	Finance	This work is now well underway: Lincoln hospital is expected to be completed by Friday 18/9/26, Pilgrim & Grantham will then be started simultaneously on Monday 21/9/26 with an expected completion date of 27/11/26. The project will then move to the identified community properties, completion date TBA	
• ensure all assets are barcoded and linked to an industry standard maintenance management system	31 March 2027		A contract to deploy the SFG20 system (maintenance worksheet system) is about to be let with the company. This project is dependant on the completion of the asset register (see above) it is also dependent on the PPM review project to ensure each asset has the correct SFG20 worksheet scheduled against it	
• move to a single asset register as part of the move a single organisation	1 April 2027 onwards		To be completed to coincide with single organisation 'Go Live'	
• carry out a review of PPM across the group to improve compliance and productivity	31 March 2026 **(PPM audit complete and report received)** 30 September 2026 **(follow-up review completed)** 9 October 2026 **(report)**		PPM audit undertaken. Final report awaited but the audit has identified the need for some remedial actions. The EFM team are enacting the changes. External partner secured to support with this work. Arising from the PPM audit the Group Chief Estates & Facilities Officer has now commissioned an independent follow-up review of the implementation of recommendations from previous EFM reviews e.g. LST, Water Safety etc. to provide assurance as to the robustness of EFM governance & assurance processes. Terms of Reference finalised and review commenced	

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

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
NHSP Transfer of Properties / Assets				
Linked to the work on the development of a comprehensive asset register for the group and the move to a single organisation, complete the work to transfer assets / properties from NHPS to the group in accordance with NHSE guidance	31 March 2027	Finance	Underway	
Linked to the above work, agree the plan for the future management of sterile services (currently managed as a shared service with NLAG)	31 March 2028		Business Case being developed Two years notice on the shared service contract to be given	
Emergency Preparedness, Resilience & Response (EPRR)				
Harmonise EPR arrangements from two legacy organisations into a single, compliant framework – aligning policies, governance, command structures and business continuity plans to meet NHSE EPRR Core Standards	31 March 2027	People & Culture	Plan in development	
Establish one integrated EPRR function with consistent capability, systems and assurance, enabling unified reporting, testing and full compliance with NHSE EPRR Core Standards across the new organisation	31 March 2027		Group lead for EPRR now appointed (commenced April 2026). Remaining restructure and integration of EPRR teams currently going through banding (due end of September 2026)	

Single Organisation Programme Plan: Work Streams, Work Pillars & SROs – Work Stream 9



Work Stream 9: People & Culture

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
People Strategy				
Develop and implement a People Plan Overarching Implementation Plan that aligns with the Trust Strategy and Single Organisation Integration Plan, by developing specific workstreams and plans to achieve these objectives to include the following specific tasks / milestones:				
• Develop and implement a People Plan	30 June 2026	Integration Delivery: Clinical Strategy	**Complete:** The People Plan ('Work Well') has been approved. Board briefing on the 'Work Well' Plan scheduled for 1 September 2026	
• Undertake due diligence under each work pillar	31 August 2026 **(review complete)** 4 September 2026 **(draft report)**		**Complete:** Culture and Legal DD are now complete. Draft Legal DD report received, and Culture DD presented to Sept Oversight Group. The programme Plan has been updated to incorporate all identified risks, recommendations and associated actions.	
• Develop an overarching People Plan aligned to the LCHG Strategy and Single Organisation Integration Plan. Use the resulting insights and data from the due diligence exercise to shape and finalise the operational and delivery plans	30 April 2026		**Complete:** An overarching People Plan is in place in support of the move to a single organisation. The plan is informed by NHSE guidance and learning from other trusts and will be further refined using due diligence insights, external strategic partner support and legal advice to finalise operational and delivery requirements. The plan will continue to be reviewed as work progresses to support the development of the Strategic Case, Full Business Case and Post Transaction Integration Plan. Action plans also in place for National Staff Survey actions. Additional actions to be added as required from the Overarching People Plan once formally approved	
• Develop specific work streams / operational delivery plans	30 September 2026		**Complete:** Post Transaction Integration Plan content submitted Due diligence outputs and the Work Well Plan will inform the pre and post Day 1 activities as outlined within the Post Transaction Integration Plan – timescale amended in line with agreed programme timelines	
• Develop and implement a comprehensive merger communication and engagement strategy, including tailored plans for staff, middle managers, clinical leaders, consultants, Trade Unions and frontline teams that covers future state and takes into account sub cultural differences	Phase 1 – March 2027 Ongoing post April 2027	Corporate Governance / Legal	The Work Well Plan has been launched and a comprehensive communication and engagement strategy is in place to support; planned to continue throughout the transaction period.	
• Develop and maintain a register of all identified workforce contractual risks, including TUPE-protected terms, inherited contractual rights, collective agreement obligations and legal constraints on harmonisation	February 2027		Not yet started	Not yet started
• Implement appropriate governance, monitoring and reporting arrangements to ensure timely and cohesive delivery of the agreed plans	30 June 2026		**Complete:** Governance and monitoring arrangements are in place with regular meetings involving Deputy Directors and Deputy Chief People Officer as operational leads, supported by a timetable for updates. Progress is informed through established reporting and a monthly written update to the Group Chief People Officer as SRO aligned to the single organisation programme timetable. As the programme has progressed, governance has been further strengthened through the allocation of Associate Directors to defined work strands to support delivery and assurance. Dedicated TEAMS channel established to assist	

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Cultural Integration & OD				
Undertake a comprehensive Cultural Integration, Transformation and Engagement Programme that utilises due diligence and staff engagement data to design a robust Organisational Development (OD) framework to unite our organisations under one set of shared values and behaviours across all leadership tiers. Supported by board-led oversight—including the remediation of cultural outliers—and establish measurable success criteria to be formally integrated into the Full Business Case (FBC) and Post-Transaction Integration Plan (PTIP). This work to take account of work already carried out linked to Better Together, Cultural Deep Dives and National Staff Survey Action Plans and include the following specific tasks / milestones:				
• Continue to implement & embed the board / executive leadership team and care group leadership OD programmes introduced to support the move to group	31 March 2026 & ongoing	Work Stream 1 Corporate Governance / Legal Communications & Engagement	**Complete:** Board Development Programme completed with NHS Providers support. Programme for 2026 / 27 developed. A 12-month ELT Development Programme was supported by Acqua. The 'LCHG Way' and LCHG Leadership Development Programme was launched in October 2025 and is ongoing	
• Undertake a programme of cultural due diligence (as required by the transaction process) in support of the move to a single organisation	31 August 2026 **(review complete)** 4 September 2026 **(draft report)**		**Complete:** Culture Due Diligence report received and presented at POG in September.	
• Utilise the findings of the cultural due diligence exercise to inform a robust cultural integration, OD & engagement plan that informs, enables and supports the establishment of an integrated culture addressing concerns identified and ensures appropriate wellbeing support	30 June 2026		**Complete:** A joint communication, staff engagement & culture programme has been agreed and is ready to launch post NHSE review of the Strategic Case. The joint communication, staff engagement& culture programme will be used to launch the 'Work Well' Plan	
• Continue to act on the results from the Staff Survey and Pulse Surveys, where appropriate, ensuring consistency across the group whilst addressing areas of specific concern	30 June 2026		**Complete:** Culture Plans that demonstrate a clear "you said, we did" feedback loop are in place for all care groups and corporate directorates.	
• Use of staff survey information (Quarterly Survey and National Staff Survey results) to help inform discussions and to capture staff perceptions of the transition and the culture and readiness for transformation change	30 September 2026		**Complete:** Joint Communication, staff engagement & culture programme agreed and provides an alternative approach	
• Increase board focus and oversight of cultural development and integration including how pockets of poor culture are being addressed by agreed reporting utilising the findings and actions from the implementation of a cultural dashboard	~~30 September 2026~~ **30 November 2026**		Focus continues on both organisational and local culture action plans. Latest NQPS2 feedback now received and being analysed. Culture plans will be reviewed and refreshed based on any new areas highlighted. Progress on delivery of culture action plans is a regular feature on the agenda of the Culture & Leadership Group, and an upward report is provided to the People Committee. The development of the cultural dashboard/heat maps is being finalised and due to be implemented in November, as the scope of this work has widened to now include quality metrics, alongside those relating to people and culture metrics – timescale amended to reflect	
• Develop an OD programme to accelerate / add greater focus to the development and embedding of a unified / integrated culture across the two organisations in support of a move to a single organisation, building on work already completed to develop a single set of values and behavioural framework for the group	31 July 2026		**Complete:** The Leadership Pathway now in place provides assurance that leadership capability, cultural alignment and people management are being strengthened to mitigate transition risks and support engagement, stability and a unified culture as the Group moves to a single NHS organisation. [The NHSE developed staff survey to be completed at FBC stage will test the effectiveness of cultural integration]	
• Review organisational development capacity and expertise required to support merger implementation and cultural integration, and develop resourcing plans where gaps exist	November 2026		Two WTF Transformation Programme Managers created within the People Programme function to support transformation programmes (inc. Single Org). One post due to start Oct 2026 – recruitment ongoing for second post.	
• Establish a cultural baseline, incorporating Staff Survey, FTSU, engagement, retention, turnover and sickness indicators; agree cultural success measures and target outcomes; and implement a culture dashboard to monitor integration progress before and after merger.	28 February 2027		Cultural dashboard and heat maps being finalised. Appointment of OD Programme lead [starts 5th Oct] will further support refinement and development of a cultural baseline	

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Change Management				
Evaluate the Trust's readiness to deliver a single organisation model by assessing organisational capability, policies and processes for complex change, and the integration of relevant legal, operational, and leadership requirements into the transition plan to include the following specific tasks / milestones:				
• Review and refresh, as required, the group Change Management Policy and supporting arrangements to ensure they remain fit for purpose in support of the move to a single organisation	30 April 2027	Corporate Governance / Legal Communications & Engagement Finance	**Complete:** The Change Management Policy has already been agreed as a group policy and is equitable across both trusts. All key contractual policies and those where an inequity of benefits existed have been agreed or are on target to be agreed. All policies will require updating to include the new trust visual ID / logo	
• Assess the current organisational capability to manage and lead complex change	30 September 2026		**Complete:** Middle Managers masterclass proposal updated following GLT feedback and supported for approve on 2 October 2026. Training will be voluntary, with targeted Wave 1 participation identified by leadership teams with sessions commencing in October 202. This replaces the self-assessment/ skills scan, with development needs addressed through leadership discussions and 1:1s.	
• Develop and implement a plan to address gaps identified in respect of capability at all levels within the group to lead and manage complex change	31 October 2026		OD and HR are developing a People Management Fundamentals session on managing complex change, including TUPE, to complement the behavioural focus of the master class. Together with the wider leadership development programme, this provides a comprehensive development offer for managers.	
• Map all existing Trade Union Recognition agreements and arrangements	30 September 2026		**Complete:** Existing recognition agreements have been collated as part of the due diligence exercise	
• Negotiate and implement a single Trade Union Recognition and Partnership Agreement, taking into consideration if recognised Trade Unions are the same across each Trust ready for the new merged Single Organisation	31 March 2027 **(developed)** 1 April 2027 **('Go Live')**		A draft Recognition Agreement has been drafted and discussions are ongoing with Staffside colleagues to agree a final version	
• Identify existing governance arrangements for People & OD areas and TOR [e.g. JNF/JNCC]	30 April 2026		**Complete:** Agreed but different governance processes and TOR exist across both organisations currently; JNF within ULTH and JNCC within LCHS.TOR for each have been reviewed to inform and develop new TOR for use in the single organisation	
• Develop governance arrangements including a single JCNC/JNF structure with agreed facility time framework	31 March 2027 **(developed)** 1 April 2027 **('Go Live')**		Terms of reference have been drafted and an initial scoping meeting has been undertaken. It is anticipated that further discussions with colleagues will allow the TOR to be presented at the August 2026 JNF/JCNC for ratification with Staff Side colleagues. Working group has been set up to viewed the Terms of Reference	
• Undertake due diligence in respect of Privacy notices and data sharing protocols that inform ways of working within HR.	1 April 2027		There are already some data sharing agreements in place e.g. ESR. Work is underway with IG to establish what needs to be put in place going forward	
• Develop and agree Privacy notice/data sharing protocols for a single organisation HR function	1 April 2027		Advice is being sought from IG to establish what is required. Some data sharing protocols are already in place e.g. ESR	
• Identify details of ongoing HR-related legal disputes	30 June 2026		This information has been collated by the end of June deadline but could potentially change if further cases transpire	
• Develop a targeted middle manager engagement and mobilisation framework to build buy-in, confidence, involvement and advocacy and maximise active participation in merger-related change and leadership development opportunities, change, communication and cultural integration initiatives. This will focus on: early information, opportunities to influence, safe spaces to raise concerns, consistent messaging and peer support, to ensure middle managers are equipped and motivated to play their critical role in delivering a successful transition to a single organisation	Start pre day 1 Continue post day 1		The final proposal for the middle managers masterclass (Leading Honest Conversations and Delivering Difficult Messages) is due to be approved at GLT on 2nd October. with sessions due to commence in October .	
• Undertake due diligence details of any employment tribunal cases, risks and associated costs	31 August 2026		**Complete:** undertaken as part of the legal due diligence work. Subject to change if further cases emerge	

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
HR Transactional including TUPE Transfer				
Undertake a comprehensive HR, Pensions, and Employee Relations due diligence exercise to inform integration planning and delivery, ensuring a legally compliant, operationally seamless, and culturally aligned transfer of all employees to the single organisation to include the following specific tasks / milestones:				
• Determine if TUPE or COSOP applies	31 March 2026	Corporate Governance / Legal Communications & Engagement Finance	**Complete:** Legal advice confirms that TUPE will apply; awaiting written confirmation. Ongoing legal advice to be sought as work progresses	
• Undertake HR and Pensions due diligence	31 August 2026		**Complete:** undertaken as part of due diligence exercise	
• Undertake analysis of numbers of bank workers including role, band and staff group (linked to Employment Rights Bill	31 March 2027		NHS Employers engaging with the government's consultation process regarding zero hour contracts and NHS inclusion; consultation process ends 25th August. This will inform detailed regulations expected to be implemented 2027	
• Collate and validate all Employee Liability Information, including identifying employees with inherited TUPE protections or non-standard contractual terms	~~28 February 2027~~ 31 January 2027		Identification and confirmation of employees in scope for transfer, preparation and validation of Employee Liability Information (ELI) form part of the ongoing and planned work to undertake the TUPE transfer as reported to oversight group October 2026 – timescale amended to reflect	
• Undertake audit of collective agreements in place, review and determine risks levels in maintaining	31 January 2027		**Complete:** Reviewed as part of the due diligence programme – no collective agreements identified	
• Identify opportunities to review / consolidate any collective agreements through agreed governance routes	28 February 2027		**Complete:** Reviewed as part of due diligence programme – no collective agreements identified	
• Map all differences in contractual and non-contractual benefits, including salary sacrifice schemes, and determine those protected under TUPE	31 August 2026 **(review complete)** December 2026 **(draft report)**		This work is being completed as part of the legal due diligence exercise – information provided. This work has already identified differences to notice periods for B7 staff and some local medical contracts of employment within LCHS Being undertaken as part of the preparation phase as outlined in TUPE paper presented to POG October 26	
• Seek guidance/identify if transfer falls under an ETO reason	31 May 2026		**Complete:** As above, legal advice confirms that TUPE will apply. Ongoing legal advice to be sought as work progresses	
• Develop benefits harmonisation options, supported by legal advice, ensuring compliance with TUPE protections	31 August 2026 **(review complete)** February 2027 **(draft report)**		All key contractual policies and those where inequity of benefits existed have been agreed or are on target to be agreed. Forms part of the ongoing due diligence and Integration Planning, date amended to reflect Being undertaken as part of the preparation phase as outlined in TUPE paper presented to POG October 26	
• Identify current status of development of group HR contractual policies	30 April 2026		**Complete:** Main contractual policies have been agreed. Further action to prioritise remaining policies to aid transaction to be undertaken as a new action in due course	

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
HR Transactional including TUPE Transfer cont'd				
Undertake a comprehensive HR, Pensions, and Employee Relations due diligence exercise to inform integration planning and delivery, ensuring a legally compliant, operationally seamless, and culturally aligned transfer of all employees to the single organisation to include the following specific tasks / milestones:				
• Develop plan to address completion of outstanding contractual HR policies prioritised to support transaction needs	30 April 2026	Corporate Governance / Legal Communications & Engagement Integration Delivery: Digital Finance	**Complete:** Plan in place. The Group Policy Committee and associated governance forums have agreed the key contractual policies. Plan in place to address remaining gaps	
• Map existing other HR policies and procedures and agree priority to complete pre-transfer	31 August 2026 **(review complete)** 31 December 2026 **(draft report)**		All contractual policies have been agreed as group policies, with the exception of Managing Attendance and Annual Leave. These have now been agreed by the Group Policy Committee and will be submitted to the next JNF/JCNC for sign off. There is a policy schedule for all other employment policies to be developed as group and ratified through the Group Policy Committee and relevant consultation forums. Due Date amended to reflect the Due Diligence work. This will negate the need to change those already completed, other than ensuring that the formatting is in line with the single organisation.	
• Identify measures – any planned changes that may impact (ETO reasons)	31 January 2027		Align with findings from Legal Due Diligence exercise. Operational TUPE plan being developed following guidance where necessary from Browne Jacobson	
• Develop delivery plan for TUPE transfer ensuring full engagement with Staff Side and taking account of legal advice	31 January 2027		HR workstream has established a comprehensive workforce transition programme to manage the transfer of approximately 2,000 employees in accordance with the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and wider employment law requirements as outlined in presentation to October 2026 Programme Oversight Group	
• Ensure delivery plan for TUPE transfer factors in notification and has sufficient administrative resources allocated to update staff and systems e.g. ESR, Health Roster, Pensions, Payroll etc.	28 February 2027		Resources needed will be monitored and reviewed as the delivery plan progresses	
• Ensure cultural and management capability and capacity is factored into what a TUPE transfer involves and their role in that	28 February 2027		A separate People Management Fundamentals session is being developed by OD and HR with a focus on "managing complex change, including TUPE", which will cover more of the process elements (with the masterclass being behavioural focused). These 2 sessions, together with the wider Leadership Development Programme cover all areas to develop managers' capability in these areas.	
• Ensure correct governance process is followed to implement the TUPE change programme	30 November 2026			Not yet started
• Review policies relating to pensions (partial retirement, retire and return etc.)	31 July 2026		**Complete**: Work undertaken to clarify position regarding guidance and polices relating to Pensions e.g. retire and return, partial retirement etc. Guidance documentation updated and submitted to Group Policy Committee in August 2026 with the development of a new Group Retirement Policy planned to go to GPC in October 2026	
• Review policy and practice on personal files including where these are held, by whom and how assurance is provided in accordance with data governance regarding storage, retention and access	1 April 2027		Plan to be developed	Not yet started
• Using information obtained from the above action, develop and implement policy and practice for a unified approach and practice for the new single organisation that is compliant with legislation (personal files)	1 April 2027		Plan to be developed	Not yet started

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
HR Transactional including TUPE Transfer cont'd				
Undertake a comprehensive HR, Pensions, and Employee Relations due diligence exercise to inform integration planning and delivery, ensuring a legally compliant, operationally seamless, and culturally aligned transfer of all employees to the single organisation to include the following specific tasks / milestones:				
• Review all HR policies to determine contractual status and identify any contractual obligations transferring under TUPE.	30 November 2026	Corporate Governance / Legal Communications & Engagement Integration Delivery: Digital Finance	Forms part of the preparation phase of the TUPE Delivery Plan as presented at POG October 2026	
• Complete review of all salary sacrifice arrangements and determine legal obligations for continued provision following transfer.	31 December 2027		Not yet started	Not yet started
• Undertake assurance review of employees identified with historic TUPE-protected rights to validate records, contractual documents and ongoing obligations to create a register of employees with known or suspected TUPE-protected contractual rights resulting from previous transfers.	31 January 2027		Forms part of the preparation work for the TUPE Delivery Plan as presented at Programme Oversight Group in October 2026	
• Establish legal review and approval process for any post-Day 1 contractual harmonisation proposals affecting transferred employees. Ensure monitoring and mitigation arrangements in place for inherited employment claims, disputes and workforce-related legal liabilities following transfer.	Approval process Pre Day 1 Monitoring Post Day 1		Not yet started	Not yet started
• Undertake a formal TUPE compliance review against all planned Day 1 and post-Day 1 workforce changes.	28 February 2027		Not yet started	Not yet started
• Map all contractual and non-contractual employee benefits across both organisations and identify areas of inequity, legal constraint and harmonisation opportunity	31 December 2026		Work ongoing with those relating to reward and recognition already completed	
• Establish a legal sign-off process for all workforce decisions arising from integration including harmonisation proposals, benefits changes, policy changes and TUPE measures.	31 December 2026		Not yet started	Not yet started
• Review all employment policies to determine whether they are contractually incorporated and assess risk associated with future harmonisation	30 November 2026		Not yet started	Not yet started
• Develop a future-state employment contract framework for all new entrants post-transfer, informed by legal due diligence findings and agreed organisational design principles.	28 February 2027		Not yet started	Not yet started

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Workforce Planning				
Implement a unified workforce integration framework that seeks to harmonise legal contractual terms, synchronises data reporting systems and metrics, and identifies key resourcing and performance management challenges to ensure a single, cohesive operational model to include the following specific tasks / milestones:				
• Develop an integrated workforce plan	1 April 2027	Corporate Governance / Legal Communications & Engagement Integration Delivery: Digital Finance Medical & Nursing	Workforce plans exist and have been submitted for each trust; work will be required to integrate these plans into a single plan	
• Develop and integrated resourcing plan	1 April 2027		Plan to be developed	Not yet started
• Ensure job evaluation panels follow group process and that trust specific processes cease	30 April 2026		**Complete:** Group process now followed for all job evaluations	
• Audit contracts of employment in both trusts to determine differences and develop a plan to determine what if any action is required or can legally be achieved in achieving unity (e.g. mobility, travel time etc.)	31 August 2026 **(review complete)** December 2026 **(draft report)**		Reviewed as part of the due diligence work undertaken by the group legal advisors – agreed that our legal advisers will, as part of this process review and identify risks of differing contracts in place.	
• Establish new contracts of employment for all staff groups for new starters post transfer	1 April 2027		Plan to be developed	Not yet started
• Working with the staff bank, design and implement new bank workers contracts take due note of forthcoming new legislation for all workers taken on post transfer	1 April 2027		Plan to be developed	Not yet started
• Undertake due diligence of all workforce reporting and targets, identifying systems used and other interdependencies and trust reporting requirements	31 August 2026		**Complete:** undertaken as part of the wider agreed Due Diligence approach	
• Audit workforce data quality	1 April 2027		Links to move to a single ESR and being planned as part of that work	
• Develop integrated workforce reporting systems and metrics for operating as a single organisation	1 April 2027		Plan to be developed	Not yet started

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Workforce Planning cont'd				
Implement a unified workforce integration framework that seeks to harmonise legal contractual terms, synchronises data reporting systems and metrics, and identifies key resourcing and performance management challenges to ensure a single, cohesive operational model to include the following specific tasks / milestones:				
• Identify / audit workforce statutory and mandatory training	30 April 2026	Corporate Governance / Legal Communications & Engagement Integration Delivery: Digital Finance Medical & Nursing	**Complete:** Latest figures for both trusts reported via HR metrics already in place	
• Gather information on support provided by training and development, clinical supervision systems, preceptorship, mentorship and competency frameworks	30 June 2026		**Complete:** Forms part of the process to develop the Post Transaction Integration Plan: integration templates drafted and include pre and post Day 1 plans aligned to the 'Work Well' Plan	
• Gather information on the revalidation process and numbers of medical staff being deferred or not put forward for revalidation	30 April 2026		**Complete:** Information available and held by Medical Director's Office	
• Identify the numbers of medical staff being managed under 'Maintaining High Professional Standards'	30 April 2026		**Complete:** Information available and held by Medical Director's Office	
• Identify the numbers of staff being investigated by the Nursing & Midwifery Council, General Medical Council and Health and Care Professions Council	30 April 2026		**Complete:** Information held and managed via existing processes	
• Collate appraisal rates	31 July 2026		**Complete:** Newly aligned timeframes for undertaking appraisals in place supported by agreed Appraisal Policy and guidance. Figures available and reported via Workforce Strategy Group with upward reporting to the People Committee	
• Review all Memorandums of Understanding (MOUs) relating to workforce employees	31 August 2026		**Complete:** Reviewed as part of the due diligence programme	
• Develop a plan to ensure all senior posts including executive posts are recruited by Day 1 with clear mitigation plans if not achieved	1 April 2027		**Complete::** Superseded by new broader action on Talent and Risk plan as below	
• Develop a retention and talent risk plan focusing on key leaders, hard-to-recruit roles and areas with elevated turnover risk during the merger transition period.	31 January 2027 Continue post day 1		Developing joint working between people portfolio areas and care group / corporate leadership teams to understand and highlight where particular 'flight' risks may be related to the merger transaction period, and then agree plans how to mitigate these. The heat maps/dashboards will also inform this where areas of elevated turnover risk is seen.	
• Undertake workforce flexibility, mobility and contract variation assessment to identify barriers to implementation of future integrated models of care and develop options to address these.	31 January 2027		Not yet started	Not yet started

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Team & System Integration				
Standardise and integrate all workforce digital systems, reporting frameworks, and People functions to establish a unified operational infrastructure that aligns with the single organisation's organisational reporting requirements				
Work up plans to move to a single Health Roster system including how any supplier / contractual issues will be addressed	1 April 2027	Corporate Governance / Legal Communications & Engagement Integration Delivery: Digital Finance Medical & Nursing Procurement	Work being undertaken by the Nursing Directorate but links to the ESR work. Allocate HealthRoster contract renewal is due in April 2027. Work is required to ensure renewal readiness. Agreed strategic requirement to technically consolidate the two HealthRoster systems across the Group, enabling greater cross-organisational workforce collaboration. The preferred approach is to merge LCHS HealthRoster into the ULTH HealthRoster (c.3,000 users into c.11,000 users). The timing of this activity will be driven by either the transition to a single organisation or the April 2027 contract renewal date, whichever occurs first. Allocate are currently preparing costings and have requested a discovery meeting to define the technical requirements, including decisions on the migration of historical LCHS roster data	
Move to a single Health Roster system / contract	TBC		As above	
Complete the work to fully integrate & embed the HR, OD, Education & Talent and Culture and Occupational Health functions	31 May 2026		**Complete:** People & Culture restructure concluded and aligns all teams under 5 distinct area of focus working across the group to deliver the 'Work Well' Plan	

Work Stream 9: People & Culture cont'd

Key Tasks / Milestones	Timescales	Interdependencies	Current Position including agreed remedial actions where progress is 'off track'	RAG
Team & System Integration cont'd				
Standardise and integrate all workforce digital systems, reporting frameworks, and People functions to establish a unified operational infrastructure that aligns with the single organisation's organisational reporting requirements				
Develop a plan to move to a single ESR (or its replacement) for the new single organisation	31 March 2027	Corporate Governance / Legal Communications & Engagement Integration Delivery: Digital Finance Medical & Nursing Procurement	Plan developed in line with ESR merger guidelines. Formal notification to IBM required to enact plan. Recommended approach will be to run systems following 'Go Live'. Due to the complexities of the technical merge and expected Go-Live date for the single organisation, a period of dual running would: - ensure continuity of payroll and workforce services - reduce implementation risk by avoiding an intense rush to move to a new technical structure - enables robust testing and assurance before full consolidation ESR data cleansing is ongoing to support transfer readiness. Work is focused on aligning LCHS ESR Structures with ULTH and improving the quality and accuracy of data	
Move to a single ESR (or its replacement) for the single organisation	1 April 2027 onwards		Plan in place which will develop and evolve over the period of the project	

Appendix A: Single Organisation Programme Delivery RAG Rating Matrix

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

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 November 2026*
Agenda item number	*8.1*

Quality Committee Upward Report of the meeting held on 15 September 2026

Accountable Director	*Nerea Odongo, Group Chief Nurse*
Presented by	*Jim Connolly, Non-Executive Director*
Author(s)	*Karen Willey, Deputy Trust Secretary - ULTH*
Recommendations / decision required	*The Group Board is asked to:* • *note the discussions and assurance received by the Quality Committee* • *note the escalations made to the Board* • *approve the attached Patient Experience Annual Report*

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
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 (i): Enhance our digital capability through innovation delivering the 10-year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	

3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	Quality Committee
Report from meeting held on:	15 September 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 15 September 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 1a(i):

a) Patient Safety Group (PSG) Upward Report
b) High Profile Cases Report

The Committee received **assurance** through the PSG upward report with Duty of Candour continuing to remain high, along with positive closure of incidents open from 2025.

Concern was noted by the group in respect of the open actions following after action reviews from Patient Safety Incident Investigations (PSII) which were being reviewed in detail at Performance Review Meetings to understand the help and support required.

Learning was taken from PSIIs with the quarterly learning report identifying the main issue being the escalation of care, further themes continue to be identified from PSIIs and a sepsis management task and finish group has been recommended.

Assurance was received from the Infection Prevention and Control update with water safety planned preventative maintenance noting to be improving for ULTH. A decline was noted for LCHS with an engineer in place to determine the issues with a risk noted at Skegness Hospital due to a positive legionella sample. It was confirmed there had been no hard however investigations were underway to identify the cause.

The Committee noted the **escalation** in relation to the ongoing deterioration of Clostridium Difficile (C-Diff) and recognised this as a strategic risk due to the impact on the National Oversight Framework (NOF). It was recognised that the trajectory was impacted by recurrent themes including isolation not being undertaken in a timely manner, step down of antibiotics and challenges with ward rounds not being undertaken by microbiologists, due to staffing issues.

A named doctor had been appointed which would drive antimicrobial stewardship and provide support whilst microbiologist vacancies continued.

As a result of the position the Committee requested a review of the C-Diff action plan, to be reported through the PSG upward report. The current risk would be reviewed to confirm if this required increasing and it was agreed an escalation would be made to the Board to ensure strategic oversight of the position and action being taken.

Discussions were held in respect of the deteriorating patient and the request that had been made to PSG for greater oversight in the absence of the Deteriorating Patient Group. Despite regular reporting to PSG improvements were not being seen and therefore consideration of actions to support improvement was needed. The Committee noted that there were currently no associated metrics in place for the deteriorating patient and these would be developed for clear oversight of the position.

Assurances in respect of Objective 1a(ii):

a) Patient Experience and Involvement Group Upward Report
b) Safeguarding and Vulnerabilities Oversight Group (SVOG) Upward Report (inc Children and Care and Childre Exploitation Report)
c) Patient Experience Annual Report (**appended**)

Assurance was received through the Patient Experience Group Upward Report with the Committee noting that the Friends and Family Test (FFT) is now back in use, whilst some data concerns were noted following the initial rollout, this was being addressed and it was confirmed there had not been an increase in PALS or complaints as a result.

Mixed Sex Accommodation (MSA) breaches were noted with 143 unjustified breaches to date with work being undertaken through a Task and Finish Group to support improvement. The Committee noted the challenges with MSA were related to flow with **assurance** received that controls were in place however confirmation of these being effective. Breaches were occurring in assessment areas, not bedded areas, however it was recognised that the risk tolerance needed to be considered as this was not an accepted position.

The SVOG upward report was received by the Committee with concern noted in respect of medical engagement in safeguarding practice and training which presented a significant risk. A medical lead for safeguarding had been

identified about would be important in ensuring critical engagement with the Care Groups.

A child exploitation audit had been undertaken at Grantham and subsequently extended to Lincoln ED and other urgent treatment centres with a Task and Finish Group stood up. The Committee noted that there was a lack of professional curiosity demonstrated and a lack of the use of assessments and tools. A request was made for a repeat audit to be undertaken at the end of quarter 4.

Capacity within the Children in Care Service was noted to be an ongoing concern despite recruitment to the medical element of the role and improvements in initial health assessment being completed. Delays continued in the nursing assessments and further conversations were required with the commissioner to ensure a sustainable service moving forward.

The Committee noted the recent court ruling in relation to Mental Capacity Act (MCA) Assessments and recognised the likely increase in court rulings impacting on clinical staff time and additional training due to the process. An update would be offered to the Committee as progress was made.

The annual report for Patient Experience was received by the Committee with the report demonstrating the volume of work undertaken during the 2025-26 year. It was noted that future work would focus on co-production at clinical business unit level, strengthening of communication, learning, improvement and strengthening of volunteer roles. The Committee commended the report to the Board for approval.

Assurances in respect of Objective 1a(iii):

a) Clinical Effectiveness Group Upward Report (CEG)

The CEG upward report was received by the Committee with the recognition that the meeting had been reduced to support staff to attend the Electronic Patient Record (EPR) training ahead of the Go Live.

Detailed updates were offered to the Committee in respect of the National Audit Data Collections, noting that there were 63 audits completed with only 10 audits having dedicated support in place.

The Committee noted that national audits were now included in the NOF and the increase in outlier alerts would impact this due to issues around data entry and collection. Work was taking place to determine the most appropriate way in which support could be provided.

Assurance was received by the CEG from the Neighbourhood Heath Service, District Nursing and Skin Integrity with Community Hospital and Children and Young People continuing to be areas of focus.

Assurances in respect of other areas:

a) Patient Story
b) Focussed Discussion – Patient Flow through the Emergency Department
c) Board Assurance Framework (BAF) 2026/27
d) Risk Report
e) Committee Performance Dashboard
f) Care Quality Commission (CQC) Actions update

The Committee received the patient story from the Complex Needs Rapid Response Service noting the impact of the service provision for patients and the link of this to the 10-year plan. The Committee commended the story to the Board.

A discussion was held in respect of the Patient Flow through the Emergency Department focussed discussion that is due to be received by the Committee in October in order for the report requirements to be clarified.

The Committee received and noted the position in respect of the Board Assurance Framework, Risk Report and the Committee Performance Dashboard. The Committee considered the areas of oversight needed in respect of high risks and performance reporting, with a referral to be made to the Integration Committee to map the full children's pathway for patients accessing services where there were risks associated with capacity.

A request would be made to the reporting groups to review the BAF and seek a recommendation from them in respect of the assurance and risk ratings

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) Antimicrobial action plan – this would be reviewed and reported to the Committee through the Patient Safety Group
b) Referral to be made to the Integration Committee to map the full children's pathway for patients accessing services where there were risks associated with capacity

4.0 Matters for reporting / escalation to the Group Board

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

a) Mixed Sex Accommodation breaches in assessment areas
b) C Difficile trajectory and antimicrobial action plan

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 escalations made to the Board
- approve the Patient Experience annual report (appended)

Jim Connolly, Non-Executive Director (Chair)

15 September 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 November 2026*
Agenda item number	*8.7*

Quality Committee Upward Report of the meeting held on 20 October 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* • *note the following attachments from the MNOG report:* ▪ *Appendix A- CNST MIS Year 8 SAB training risk v1.0 11102026* ▪ *Appendix 3.1- CNST MIS Year 8 mid-point review V1.1 0192026* ▪ *Appendix 3.2- MCB implementation tool ULTH V1.4 28092026* ▪ *Appendix 3.3-10PP Assurance Template v1.0 020926* ▪ *Appendix 5.0- Integrated workforce report V1.0 17082026 1* ▪ *Appendix 6.0 - Learning and Actions Thematic Report Q1 2026* ▪ *Appendix 6.4- PMRT Q1 report – Non-identifiable data* ▪ *Appendix 6.5- Claims Scorecard Q1 '26-'27*

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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	

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 (i): Enhance our digital capability through innovation delivering the 10-year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	Quality Committee
Report from meeting held on:	20 October 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 October 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 1a (i):

a) Patient Safety Group (PSG) Upward Report
b) Maternity and Neonatal Oversight Group (MNOG) Upward Report
c) Ward Accreditation Report
d) High Profile Cases Report

The PSG upward report informed the Committee each relevant care group had been asked to provide closure trajectories for overdue open actions in November 2026. The report noted that these closure trajectories would be monitored through the Performance Review Meetings process.

The report noted that in relation to the CQC and the Committee's concerns over delays in responding to deteriorating patients, the PSG had been refocused to ensure that the deteriorating patient issue was no longer a standalone item. The PSG had taken steps to incorporate the deteriorating patient theme in all its discussions and had also taken note of the work now being undertaken to improve the recognition of patients who were deteriorating.

The associated Infection Prevention and Control (IPC) report included a Reduction and Recovery Plan prepared in response to the Committee's concerns over the deteriorating position in respect of Clostridioides difficile infection (CDI) and Escherichia coli (E. coli) bacteraemia. The Plan outlined the current position, identified key contributory factors, and proposed a

recovery framework, improvement actions, and governance arrangements to support the improvement trajectory.

The Committee noted that, to successfully implement the plan, there was a strong need to closely align patient flow practices to IPC recommendations and to improve medical staff engagement. There would also be the need to decrease the risk of infection by addressing IPC environmental concerns and by procuring the recommended air filtration technology.

The Committee was **reasonably assured** by the PSG upward report and the associated IPC report.

The Committee received the MNOG upward report and noted the following:

- The organisation's submission against the national 10 Point Plan has been completed and submitted to the region within the required timeframe (**attached – Appendix 3.3**). Progress and resulting action plans will be reported through the existing governance routes.

The Committee noted the following updates, reports and accompanying appendices to the Group Board in line with CNST MIS Year 8 recommendations (**attached – Appendix 3.1**):

- Safety action A: Workforce – i) Neonatal services continue to demonstrate overall stable performance, with compliance against Qualified in Speciality (QIS) trajectories maintained; ii) The Trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline; iii) Upwardly report in full the six-monthly integrated workforce report (**attached – Appendix 5.0**) covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.
- Safety action B: Training – i) The service has achieved compliance with all staff groups and training requirements at the July touchpoint; ii) Following the mid-point review, the risk profile has increased. While compliance with the CNST training requirements remains achievable, delivery is now heavily reliant on attendance at the remaining sessions, particularly within anaesthetics, where workforce pressures and limited ability to release staff for training have significantly increased the risk of non-compliance (**attached – Appendix A**).
- Safety action C: Learning from review and investigation – i) Within the CNST MIS Year 8 reporting period there have been 7 MNSI cases to date; with 3 referred via the Early Notification Scheme. Duty of candour completed for all cases (written and verbal, in the patient's own language); ii) Upwardly report in full the quarterly Learning and Actions Thematic Report (**attached – Appendices 6.0, 6.4, 6.5**).
- Safety action E: Care Bundles – i) The service remains 100%compliant across all six elements of the Saving Babies' Lives Care Bundle.

In relation to the current position with the Maternal Care Bundle, Group Board is asked to:

- Note that Maternity Services are only able to provide limited assurance against the recommendation to achieve full implementation of the Maternal Care Bundle by March 2027 in line with the NHS England Maternity and Neonatal Services 10-Point Plan.

In relation to the plan to implement the Maternal Care Bundle, Group Board is asked to:

- Formally approve the implementation plan that sets out clear milestones, responsibilities and timescales for achieving full Maternal Care Bundle delivery, following Trust Assessor validation of the quarterly assessment on behalf of the Trust Board. (**attached – Appendix 3.2**).

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

The Committee received a report which noted the substantial work being undertaken in the Group to comply with the findings and recommendations from the Thirlwall Inquiry Report published in September 2026. The Committee was informed the People Committee at its meeting in October 2026 had reviewed the Inquiry Report from a 'people' perspective. The Committee was **assured** that the findings and recommendations will be acted upon to ensure that babies receiving care are kept safe by effective governance arrangements, clinical pathways, workforce training, organisational culture, and assurance mechanisms

It is to be noted that the inquiry had examined the events surrounding the crimes of former neonatal nurse Lucy Letby at the Countess of Chester Hospital and the wider leadership, governance, cultural and system factors that affected the recognition and response to concerns.

The Committee received and was **reasonably assured** by a Nursing Ward Quality Accreditation (NQA) report. The Committee was informed that, following the CQC visits to the EDs in August and September 2026, 2 ward areas and the 2 EDs were identified as where accreditation performance, quality indicators, workforce challenges or broader team dynamics warranted additional monitoring and support. The report stated that the 4 areas had been placed under escalated oversight, so that improvement actions could be implemented. The report also highlighted a proposal on how the ward accreditation and escalation processes should be improved.

The report noted that the 2 ward areas had improved and was no longer under escalated oversight. Of the 2 EDs, Pilgrim ED after demonstrating sustained improvement across several key quality and patient safety indicators had been de-escalated from enhanced monitoring. The Lincoln ED remain under escalated oversight with the deployment of a team of experienced senior nurses to provide focused support, clinical leadership, and oversight of improvement activity. The purpose of the additional is to support the delivery of agreed improvement plans, strengthening governance arrangements, and provide operational support to frontline teams.

The Committee received and was **assured** by a report which reported a summary of on-going high profile, significant patient safety-related cases that may also generate adverse media, social media or regulatory attention. The report noted that such cases could represent a risk to the reputation of the Group.

Assurances in respect of Objective 1a (ii):

a) Patient Experience and Involvement Group (PEIG) Upward Report
b) National Inpatient Survey 2025 – 2026
c) Child and Young Persons' Oversight Group (CYPOG) Upward Report

The Committee received the PEIG Upward Report and noted that the Group had aligned its separate patients' panels into one Group-wide co-production panel. The report noted that the new co-production panel was more diverse than the former patients' panels, which would help in the effort to improve engagement with all sectors of the communities served by the Group.

The report informed the Committee that a LGBTQ+ Inclusive Care and Support Task and Finish Group had been created in the Group. The Committee noted that the LGBTQ+ inclusive group's first meeting had taken place, and initial actions had been agreed for progression.

The report noted that the step to create the LGBTQ+ inclusive group was in reaction to feedback received by the Group's Pride Network at the last Pride event in August 2026. The feedback from the LGBTQ+ community informed the Group of the difficulties they encountered around accessing health care and their fear of experiencing prejudice. The remit of the LGBTQ+ inclusive group was to work with the Group's Pride Network to address the issues around access and the experience of care for the LGBTQ+ community.

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

The Committee received a report which provided the Committee with **reasonable assurance** on the NHS Adult Inpatient Survey 2025 - 2026 results for ULTH. The survey had a response rate of 43%, compared with the national response rate of 38%. The report highlighted the principal areas of positive performance and concern, assessed the extent to which current improvement activity addressed the findings, identified remaining gaps, and set out the proposed next steps and governance arrangements.

The Committee noted the gaps identified by the survey findings were around the themes: Medical Communication and Involvement; Staff Responsiveness; Discharge Planning and Shared Decision Making; and Discharge Information and Medicines. The Committee also noted the improvement work already underway and would receive progress updates once the medical response and detailed improvement actions were confirmed.

The Committee received a CYPOG report which highlighted the progress which had continued across several strategic priorities. The report noted the positive movement in acute paediatric service redesign, community paediatric transformation, safeguarding integration, specialist service development and workforce capability.

The Committee was **assured** that no new significant risks required escalation and that the overall trajectory across Children's Services remained positive.

Assurances in respect of Objective 1a (iii):

a) Clinical Effectiveness Group Upward Report (CEG)
b) Medicines Quality and Safety Group (MQSG) Upward Report
c) Pharmacy Aseptic Services: Capacity Policy 2026

The Committee received the CEG upward report which highlighted the shortage of Medical Physics Experts in both the Radiotherapy Physics and Nuclear Medicine services. The report stated that, while recruitment and workforce development plans were being implemented, the staffing shortfall continued to present a risk to service resilience.

The Committee was informed that the CEG had discussed a significant concern related to the unauthorised access to mortuary areas in the NHS. The CEG noted that this remains a serious issue given previous national learning and established expectations regarding access control to sensitive areas. In relation to this concern, the Group undertook a retrospective review to assess compliance with the recommendations from the Nottingham maternity review findings on post-death care and the Independent Inquiry into the issues raised by the David Fuller case. The assessment found that, over the last 15 years, there had been 3 cases of unauthorised access to the Group’s mortuaries. These cases had been submitted to the Human Tissue Authority (HTA), and they had accepted and closed those cases because they were deemed as being near misses with no harm.

The Committee was **reasonably assured** by the contents of the CEG report.

The Committee received the MQSG Upward Report which provided the assurance that medicines governance arrangements remained effective with continued compliance with NICE and medicines related audit requirements. The report also highlighted the work being undertaken to develop a sustainable pharmacy workforce model which would ensure that there was the appropriate deployment of staff from the front door to all relevant clinical areas and services.

The report noted that performance in relation to medicines reconciliation improved over Q1 of 2026/27 but remained below the national target. The Committee noted that the improvement actions being implemented by the Medicines Safety Team were being limited by capacity issues. The Committee also noted that the Pharmacy Team had reviewed the medicines

reconciliation risk and had implemented mitigating actions while continuing with the improvement actions.

The Committee was **reasonably assured** by the MQSG report.

The Committee received the revised Aseptic Services Capacity policy, which had been developed in response to external inspection feedback and evolving national expectations. The revised policy strengthened the arrangements for monitoring and managing Aseptic Services capacity to ensure that the increasing workload could be delivered safely and compliantly.

The Committee **noted** that the revised policy provided a more robust framework for identifying emergency capacity risks early and ensured that these were escalated appropriately where organisational support or investment may be required.

Assurances in respect of other areas:

a) Patient Story – Pelvic Late Effects Service
b) Board Assurance Framework (BAF) 2026/27
c) Focussed Discussion – Emergency Department (ED) Flow including Seated and Corridor Care Update
d) Risk Register Report
e) Policy Position Update
f) CQC Actions Update and Emergency Department Oversight Group Upward Report
g) Committee Performance Dashboard
h) Quality Impact Assessment Assurance Report

The Committee received the patient story on the Pelvic Late Effects Service, which had only one staff member and was for people who were 18 years and over. The Service's remit was to help cancer patients manage the effects of their Radiotherapy treatment six months after completing it. The Committee was informed that this was very helpful as the effects could be very uncomfortable or limiting even if they were temporary. The Committee recommended the patient story to the Group Board.

The Committee received a paper which showed that meaningful progress had been made in strengthening oversight, governance and assurance arrangements for patients receiving care within the ED, including seated and corridor care environments. The programme was aligned to NHSE's corridor care principles and the recommendations arising from the Health Services Safety Investigations Body (HSSIB) national investigation, with a focus on improving risk identification, harm monitoring, patient experience and governance.

The Committee received a report on the immediate actions implemented in response to the areas of focus identified by the CQC during their unannounced inspections of the EDs at Lincoln County Hospital and Pilgrim

Hospital in August 2026 and again in September 2026. The report highlighted the key improvements made since the inspections, including those around improved clinical oversight, proactive workforce management and environmental improvements.

The report highlighted the key learnings as that: a) despite significant work, previous improvement actions had not yet delivered sufficiently consistent and sustained improvement. This was because higher activity and prolonged congestion have increased reliance on escalation areas and corridor care, affecting privacy, dignity, infection prevention and the delivery of fundamental care. b) Medicines management reviews identified gaps in pharmacy provision within ED. A trial of additional pharmacy support had improved medicines reconciliation but limited ongoing provision had affected the Group's ability to sustain compliance. c) There had been considerable work already undertaken by the ED teams around leadership and organisational development support, particularly at Lincoln. Other actions implemented included the establishment of an ED patient forum, increased Quality Matron presence, and a single front door model, among others. The combination of persistent flow pressures, skill mix challenges and the need to embed changes in leadership and culture have, however, slowed progress.

The report noted that the ongoing discharge transformation work, continued IPC support and clearer separation of waiting, admitted and CDU patients are intended to reduce congestion and improve visibility and clinical oversight. The ED improvement team will support the further work needed to embed consistent leadership, teamwork and culture.

The Committee was **assured** that through the newly established ED Oversight Group and ongoing scrutiny of the inspection action plan, the Group would be focused on ensuring that patients experience safer, timelier and more compassionate care. There would be clear ownership, delivery timescales and evidence of sustained improvement, alongside transparent escalation where progress remains insufficient.

The Committee received and noted the position in respect of the Board Assurance Framework, Risk Register Report, Policy Position Update, Committee Performance Dashboard and the Quality Impact Assessment.

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 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 following attachments from the MNOG report:
  - Appendix A- CNST MIS Year 8 SAB training risk v1.0 11102026
  - Appendix 3.1- CNST MIS Year 8 mid-point review V1.1 0192026
  - Appendix 3.1.1- NHSR Assurance Visit Feedback - Lincolnshire -29072026
  - Appendix 3.1.2- Trust Board Proposal for Oversight and Assurance of Maternal Care Bundle V1.1 11082026
  - Appendix 3.2- MCB implementation tool ULTH V1.4 28092026
  - Appendix 3.3-10PP Assurance Template v1.0 020926
  - Appendix 5.0- Integrated workforce report V1.0 17082026 1
  - Appendix 6.0 - Learning and Actions Thematic Report Q1 2026
  - Appendix 6.1 - LMNS QS report April 2026
  - Appendix 6.2 - LMNS QS report May 2026
  - Appendix 6.3 - LMNS QS report June 2026
  - Appendix 6.4- PMRT Q1 report - None identifiable data
  - Appendix 6.5- Claims Scorecard Q1 '26-'27
  - Appendix 6.6 - ToR for Stillbirths review Version 1

Jim Connolly, Non-Executive Director (Chair)

20 October 2026

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission process. Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:	United Lincolnshire Hospitals Trust
Report prepared by:	Jules Bambridge - Consultant Midwife
Report date:	27/08/2026
Reporting period covered:	

Baseline Assessment		
Key Metrics		
Total deliverables		**26**
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	**Total**	**Not applicable**	**Non-compliant**	**Partially compliant**	**Compliant**
1. Listening to women and families by rolling out Martha's Rule	**1**	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	**3**	0	3	0	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	**2**	0	0	2	0
5. Addressing inequalities in maternity and neonatal outcomes	**3**	0	0	3	0
6. Ensuring 24/7 safety and responsiveness of services	**7**	0	0	6	1
7. Trust review of homebirth services	**2**	0	0	2	0
8. Responding to incidents, complaints and concerns with humanity and candour	**3**	0	0	0	3
9. Deliver safe and effective triage in maternity services	**3**	0	0	3	0
10. Post death care	**2**	0	0	0	2

Progress Report		
Key Metrics		
Total deliverables		**26**
Delivery status	Not started	**0**
	In progress	**0**
	Complete	**0**
	On hold	**0**
RAG	RAG - Red	**0**
	RAG - Amber	**0**
	RAG - Green	**0**

Summary by Action - Progress Report		Current Status					RAG (deliverables)		
Action	**Total**	**Not Started**	**On hold**	**In progress**	**Complete**	**Completed at baseline**	**Red**	**Amber**	**Green**
1. Listening to women and families by rolling out Martha's Rule	**1**	0	0	0	0	0	0	0	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	**3**	0	0	0	0	0	0	0	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	**2**	0	0	0	0	0	0	0	0
5. Addressing inequalities in maternity and neonatal outcomes	**3**	0	0	0	0	0	0	0	0
6. Ensuring 24/7 safety and responsiveness of services	**7**	0	0	0	0	0	0	0	0
7. Trust review of homebirth services	**2**	0	0	0	0	0	0	0	0
8. Responding to incidents, complaints and concerns with humanity and candour	**3**	0	0	0	0	0	0	0	0
9. Deliver safe and effective triage in maternity services	**3**	0	0	0	0	0	0	0	0
10. Post death care	**2**	0	0	0	0	0	0	0	0

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms
the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the
extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore*
'Not applicable' would be apply.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

To be completed once, at the start of the reporting cycle, to establish the trust's baseline position for each action before tracking ongoing progress.

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template							To be completed by regions			
No.	**Deliverable / Scoping Prompt**	**Baseline Compliance Rating**	**Baseline Evidence Reference** *Please input reference number as listed in 3. Evidence Log tab*		**Gaps in Assurance** *Please provide detail of any gaps in assurance*	**Improvement Actions (Including Temporary Mitigations)**	**Comments**	**Regional Compliance Rating**	**Baseline vs Regional Compliance Match?**	**Comments**	**Follow up actions and improvements required**
1. Listening to women and families by rolling out Martha's Rule			**EXAMPLE EVIDENCE**	**SAVED EVIDENCE**							
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	Not required	n/a	Trustwide Implementation in progress (known as Call for Concern locally), awaiting guidance on Patient Wellbeing Questionnaires and digital solution for this.	HOM Georgina Gould working with Trust lead Rebecca Edwardes to rollout ifully in Maternity, badgernet update expected to enable digital integration of PWQ					
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.											
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Non-compliant	▪ Analytical reports	EV-02.1-01 DRAFT Maternity Patient Experience Framework EV-02.1-02 Patient Experience update Report August 2026	Patient Experience data collection framework in development and awaiting Trustwide launch of FFT via Civica	Patient Experience Framework proposed in draft form to improve data collection and triangulate themes.,					
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Non-compliant	▪ Board report and minutes		Quarterly patient experience report with progress on CQC maternity survey and locally agreed pateint experience actions included, to be exapnded to include FFT when launched.						
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant	▪ Board report and minutes ▪ Quarterly MIS thematic report		Not currently in process as this data not easily collated, to be included from next quartely report.						
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care											
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant	▪ Board ToR ▪ Job plans		Medical Directors - Ciro Rinaldi Chief Nurse - Nerea Odongo						
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	▪ Job plans ▪ Minutes of Executive board meetings								
5. Addressing inequalities in maternity and neonatal outcomes											

5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant	▪ Board report and minutes	EV-05.1-01 EMAIL Perinatal Equity and Anti-Discrimination Programme (PEADP) - Welcome to the Programme	Team of staff assigned to PEADP programme							
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	▪ Board report ▪ Quarterly MIS thematic report ▪ Equity dashboard reports ▪ Core20PLUS5 reporting ▪ Maternity equity action plans	EV-05.2 Maternity & Neonatal Equalities Dashboard Review	First inequalities dashboard review to be presented at September MNOG							
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	▪ Maternal Care Bundle implementation plans. ▪ Board Report ▪ MIS return		MCB Implementation plan to be presented at September MNOG for upward approval							
6. Ensuring 24/7 safety and responsiveness of services												
6.1	Is the trust complying with the RCOG “Roles and Responsibilities of the Consultant providing acute care” standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Partially compliant	▪ Workforce plan ▪ Biannual workforce papers ▪ Staff experience survey ▪ Cappuccini-style assurance exercise		Year 8 audit congoing							
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Partially compliant	▪ Database		Year 8 in progress							
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	▪ Workforce plan ▪ Biannual workforce papers ▪ BAPM workforce standards compliance ▪ Staff experience survey		Year 8 in progress							
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Partially compliant	▪ BR+ review and workforce plan ▪ Biannual workforce papers ▪ Staff experience survey		Year 8 in progress							
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Partially compliant	▪ Workforce plan ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise		Year 8 in progress							
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	▪ Board report and minutes ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise									
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	▪ Board report and minutes ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise		Workforce planning review currently underway							
7. Trust review of homebirth services												
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Partially compliant	▪ Board report and minutes	EV-07.01 CMW and HB escalation data report EV-07.02 PFD Cahill Summary EV-07.03 Homebirth and Inpatient Escalation Options Appraisal	An urgent review of the Homebirth Service has been completed and has provided assurance regarding staff competence and training. The review has also identified a number of service vulnerabilities and areas requiring improvement. Work is currently underway to strengthen assurance regarding workforce, to reduce service cancellations, develop a formal improvement plan, and ensure robust reporting through Trust governance structures and to NHS England. The current RAG ratings reflect an honest assessment of progress and recognise that, although important work has been completed, substantive governance and improvement actions remain outstanding before full assurance can be provided.							

7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Partially compliant	• Correspondence								
8. Responding to incidents, complaints and concerns with humanity and candour											
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.	EV-8.1-01 Trustwide PSIRF SOP							
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.	EV-8.2-01 Thematic review of maternity complaints July-Dec 25 EV-8.2-02 Thematic review of maternity complaints Jan - Jun 26 EV-8.2-02 Claims Scorecard Q1 2627 EV-8.2-03 Claims							
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families								
9. Deliver safe and effective triage in maternity services											
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	• Triage Benchmarking tool completed template		Benchmarking against recent maternity triage standards underway for reporting at September MNOG						
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	• Board paper								
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	• Plan and progress reports		On track - plan in place for implementation of 24/7 telephone triage						
10. Post death care											
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	• Assurance statement	EV-10.1-01 Assurance Statement	Assurance Statement submitted to Trust Board						
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	•Board Report •Review report								

Submission B: Progress against baseline (December 2026)

This template should be completed and submitted on **Thursday 31st December 2026**. This template reports on progress against the baseline assessment. Where a deliverable has already been reported as achieved in the baseline assessment, trusts should not complete this information again. The baseline status will automatically update and should indicate where any progress updates are required.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

									To be completed by Regions	
No.	**Deliverable**	**Baseline Compliance Rating**	**Current Status**	**RAG**	**Evidence ID** *Please input reference number as listed in 3. Evidence Log tab*	**Key Gaps / Risks**	**Improvement action required**	**Due Date(s)**	**Regional Compliance Rating**	**Comments**
1. Listening to women and families by rolling out Martha's Rule										
1.1	Is the trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Partially compliant							Non-compliant	
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level										
2.1	Has the trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Non-compliant								
2.2	Is the trust board continuing to receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Non-compliant								
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Non-compliant								
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care										
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant								
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant								
5. Addressing inequalities in maternity and neonatal outcomes										
5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant								
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant								
5.3	Is the trust board receiving reviewing and acting on (through the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	Partially compliant								
6. Ensuring 24/7 safety and responsiveness of services										

6.1	Is the trust complying with the RCOG “Roles and Responsibilities of the Consultant providing acute care” standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Partially compliant								
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Partially compliant								
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant								
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Partially compliant								
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	Partially compliant								
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?									
6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant								
7. Trust review of homebirth services										
7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	Partially compliant								
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Partially compliant								
8. Responding to incidents, complaints and concerns with humanity and candour										
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant								
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant								
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant								
9. Deliver safe and effective triage in maternity services										

9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant									
9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalitie?	Partially compliant									
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant									
10. Post death care											
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant									
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant									

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01		not required						
EV-02		Framework	EV-02.1-01 DRAFT Maternity Patient Experience Framework	24th Aug 26	Katy carr			
		Report	EV-02.1-02 Patient Experience update Report August 2026	1st Aug 26	Katy Carr			
EV-03								
EV-04								
EV-05		Correspondance	EV-05.1-01 EMAIL Perinatal Equity and Anti-Discrimination Programme (PEA	18th Aug 26	Jules Bambridge			
		Report	EV-05.2-01 Maternity & Neonatal Equalities Dashboard Review	1st Sep 26	Jules Bambridge			
EV-06								
EV-07		Report	EV-07.1-01 CMW and HB escalation data report	28th Oct 25	Emma Upjohn	U:\Midwifery\Action plans & evidence\10 Point Plan\Evidence Folder\EV-07.01 CMW and HB escalation data report.docx		
		Summary	EV-07.1-02 PFD Cahill Summary	13th Nov 25	Emma Upjohn			
		Options Appraisal	EV-07.1-03 Homebirth and Inpatient Escalation Options Appraisal	1st Jun 26	Georgina Gould			
EV-08		Report	EV-08.2-01 Thematic Review of Complaints Jun - Dec 25	29th June 26	Emma Upjohn			
		Report	EV-8.2-02 Thematic review of maternity complaints Jan - Jun 26		Emma Upjohn			
		Report	EV-8.2-03 Claims Scorecard Q1 2627		Gemma Rayner			
		Report	EV-8.2-04 Claims Scorecard Q4 2526		Gemma Rayner			
EV-09								
EV-10		Assurance Statement	EV-10.1-01 Assurance Statement	30th Jul 26	Jeremy Daws			

EV-8.2-01 Thematic review of maternity complaints July-Dec 25

EV-8.2-02 Thematic review of maternity complaints Jan - Jun 26

EV-8.2-02 Claims Scorecard Q1 2627

EV-8.2-03 Claims Scorecard Q4 2526

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance**. Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	▪ Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to undertstand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	▪ Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	▪ Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	▪ Board report and minutes ▪ Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	▪ Board ToR ▪ Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	▪ Job plans ▪ Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	▪ Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	▪ Board report ▪ Quarterly MIS thematic report ▪ Equity dashboard reports ▪ Core20PLUS5 reporting ▪ Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	▪ Maternal Care Bundle implementation plans. ▪ Board Report ▪ MIS return
	6.1	Is the trust complying with the RCOG “Roles and Responsibilities of the Consultant providing acute care” standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	▪ Workforce plan ▪ Biannual workforce papers ▪ Staff experience survey ▪ Cappuccini-style assurance exercise

Action 6	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	▪ Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	▪ Workforce plan ▪ Biannual workforce papers ▪ BAPM workforce standards compliance ▪ Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	▪ BR+ review and workforce plan ▪ Biannual workforce papers ▪ Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	▪ Workforce plan ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	▪ Board report and minutes ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	▪ Board report and minutes ▪ Biannual workforce papers ▪ Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	▪ Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	▪ Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	▪ Board report and minutes ▪ A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services ▪ PSIRF implementation within Maternity and Neonatal Services, governance and review processes. ▪ Process for sharing outcomes and learning from PSIRF reviews with women and families. ▪ Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	▪ Board report and minutes ▪ Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. ▪ Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	▪ Board report and minutes ▪ Debrief guidance ▪ Education and Training for Staff involved in debriefing women and families
	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	▪ Triage Benchmarking tool completed template

Action 9	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	▪ Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	▪ Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	▪ Assurance statement
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	▪Board Report ▪Review report

Maternity

United Lincolnshire Teaching Hospitals NHS Trust

Clinical Negligence Scheme for Trusts

Year 8: Maternity (Perinatal) Incentive Scheme mid-year report

Amy Garratt
Maternity Safety Lead Midwife
Version 1.1
01/09/2026

Contents

Executive summary 2
Supporting information 3
Current position 4
Safety Action A: Workforce and capacity 4
Safety Action B: Training 8
Training compliance: Trust selected checkpoint (July 2026) 12
Safety Action C: Learning from reviews and investigations 13
Safety Action D: Service-user voice and equity 16
Safety Action E: Care bundles 17
NHSR Assurance visit-formal feedback: 17
Safety Action F: Board oversight, governance, culture and leadership 21
Conclusion: 23
Annexe 24
A1: Introduction 24
A2: Background 24
A3: Reporting process 25
A4: Submission conditions 26

Caring and building a healthier future for all

A5: Additional assurance 27
A6: Reporting requirements and frequency 27

Executive summary

iNeed *Making escalation easier*	**To ALERT** *What we need you to know*	**To ADVISE** *What we are already doing*	**To ASK** *What we need from you*	**To ASSURE** *What is on track*
Overall progress	The Trust remains on a positive trajectory towards achieving CNST MIS Year 8. The majority of safety actions are progressing as planned, supported by robust governance arrangements and positive feedback from the NHSR Assurance Visit.	Delivery is overseen through the Maternity and Neonatal Oversight Group (MNOG), Quality Committee and Trust Board with relevant escalations in line with the PQOM	No significant escalations identified across Workforce, Learning from Reviews, Care Bundles or Governance Actions	All six CNST MIS Year 8 safety actions are currently assessed as either on track or progressing as planned. The Trust has achieved alignment with Birthrate Plus recommendations, demonstrated sustained progress against neonatal QIS trajectories, maintained compliance with review and investigation requirements, exceeded simulation training expectations, achieved 100% compliance with Saving Babies' Lives Care Bundle requirements, and received highly positive NHSR assurance feedback describing the organisation as well prepared, transparent and improvement focused.
SA B: Training	The principal risk remains achievement of the November 2026 training compliance thresholds.	Whilst delivery plans are in place and July compliance standards were achieved, success remains dependent	Continued Board support is requested to reinforce training attendance as an organisational priority and	All sessions are booked, with trajectories indicating 90% compliance is achievable. Compliance monitored through MNOG with early escalation routes identified.

		on training being protected, staff attending booked sessions, and minimal redeployment from training.	to minimise non-essential redeployment from booked training sessions.	
SA D: Care bundles	CNST requirement should be achieved however, full implementation of the Maternal Care Bundle by March 2027 is also expected to present a significant challenge nationally due to the scale of workforce, operational and system changes required.	Governance and assurance framework agreed in principle at GCQ in August; implementation plan in development; phased oversight through MNOG, GQC and Board.	Ongoing executive support will also be required to maintain oversight of Maternal Care Bundle implementation planning and associated resource implications as national requirements continue to develop.	Implementation tool now complete in preparation for presentation at September MNOG in line with governance framework.

Supporting information

To streamline the main body of this report and avoid duplication with information presented in previous CNST MIS updates, the detailed background, governance arrangements, reporting processes, submission requirements, declaration conditions, and reporting requirements have been moved to the annexe. This information remains unchanged from previous reports and continues to provide the governance framework supporting delivery of CNST MIS Year 8. The main report therefore focuses on current performance, progress, risks, assurance and exceptions requiring discussion or escalation, whilst the annexe remains available for reference.

Current position

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	0	7	0	0	7
B	0	2	3	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	0	0	3	0	0	3
F	0	0	4	0	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	0	2	25	0	0	

Safety Action A: Workforce and capacity

Sub-action reference	Sub-action description	Detail

A1 **In progress & on track**	**Consultant attendance (obstetric workforce)** Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations. • *For presentation of findings at MNOG November 2026*	• Attendance in acute care settings is routinely recorded and reviewed, ensuring alignment with workforce expectations and enabling ongoing oversight of consultant presence during defined high-risk clinical situations. • Audit underway: December 2025- June 2026 • Significant challenges identified with BadgerNet documentation
A2 **In progress & on track**	**Short-term locum certification (obstetric workforce)** Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register. • *For presentation of findings at MNOG January 2026*	**August update:** • During the current reporting period, obstetric rota gaps have continued to be managed through internal locum arrangements undertaken by substantive doctors already working within the service. No external short-term locum doctors have been utilised during this period. • Assurance arrangements established following the Year 6 review remain embedded within Year 8 and include ongoing oversight of locum utilisation, recruitment processes, workforce governance and medical staffing metrics.
A3	**Neonatal workforce establishment (nursing & medical)** Trusts must have a clear plan for a	• The neonatal medical workforce remains compliant with BAPM standards for the unit designation, with establishment and workforce planning arrangements in place to maintain compliance. • QIS trajectories continue to demonstrate sustained progress across both units. At LCH, QIS compliance is 78.2% (15.73 WTE QIS of 20.11 WTE qualified staff), with 2 WTE currently

In progress & on track	fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).	undertaking QIS training through Nottingham and Leicester Universities. At PHB, QIS compliance is 83.1% (12.77 WTE QIS of 15.37 WTE qualified staff), with 1 WTE undertaking QIS training. • Progress against the QIS trajectory is monitored and reported bi-monthly through MNOG, Quality Committee and Trust Board, providing assurance of continued progress towards BAPM workforce standards. In recognition of the sustained improvement and robust governance arrangements, the neonatal QIS workforce risk has been removed from the Trust Risk Register.
A4 **In progress & on track**	**Midwifery workforce establishment** Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.	**August update:** • The Trust is now aligned with the Birthrate Plus (BR+) recommended establishment, following the implementation of workforce mitigations and establishment uplift. The temporary increase of 5.25 WTE midwives and 5.25 WTE Band 3 maternity support workers, introduced in May 2025, alongside successful recruitment and workforce planning activity, has enabled the service to achieve the staffing levels required to meet the BR+ recommendations. • To maintain compliance and ensure future workforce requirements continue to be accurately reflected, the Trust has committed £15,000 funding for the next Birthrate Plus review, scheduled for later this year.
A5 **In progress & on track**	**Anaesthetic workforce** Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained	• Obstetric anaesthetic provision at Lincoln is supported by a planned consultant and middle-grade rota that provides continuous service cover and escalation arrangements: o The on-call Consultant Anaesthetist (08:00-18:00) is job planned Monday to Friday. o A middle-grade anaesthetist (08:00-20:30) is job planned seven days per week. o Overnight middle-grade cover (20:00-08:30) is job planned, with gaps occurring on four nights in every eight-week rota cycle. o Elective caesarean section activity is job planned on Tuesday to Friday mornings

	anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.	Obstetric anaesthetic provision at Boston is *supported by a planned consultant and middle-grade rota that provides continuous service cover and escalation arrangements:* • There is a separate on-call Obstetric Consultant Anaesthetist (08:00-18:00) which is job planned Monday, Tuesday and Thursday (on the days where there is no dedicated elective c/section list) • A middle-grade anaesthetist (08:00-20:30) is Job planned 7 days a week. • Overnight middle-grade cover (20:00-08:30) is job planned 7 days a week. • Elective caesarean section activity is job planned on Wednesday all day and Friday morning. Tuesday is fixed to a consultant's job plan. Wednesday to Friday is still covered but by a consultant due to work a flexible theatre session that day or by extra duty cover. • At both sites, where middle-grade rota gaps occur overnight, these are mitigated through appropriate middle-grade cover arrangements to maintain safe service provision. A Consultant Anaesthetist is always available out of hours for advice, support, and escalation, ensuring timely senior clinical input and maintaining patient safety across the maternity service.
A6 **In progress and on track**	**Planned Caesarean birth capacity mapping** Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery → postnatal ward). Trusts should use existing NHS England regional maternity SitRep data wherever possible to avoid duplication.	• Action A6 is no longer considered at risk and remains in progress and on track. • Multidisciplinary meetings between the midwifery and obstetric teams continue to review planned caesarean birth activity, capacity and flow across both maternity sites. • Data has now been collected and collated from both Lincoln and Boston, covering the planned caesarean birth pathway from pre-operative assessment through theatre, recovery and postnatal care. • Findings from the review are to be analysed and triangulated with operational, workforce and activity data to identify opportunities for improvement and support future service planning. • A report detailing the findings and recommendations is in development and will be presented through the appropriate governance structures. • Resulting actions will be incorporated into the Perinatal System Improvement Plan (PeriSIP) to support ongoing monitoring and delivery.
A7	**Board and governance oversight (as detailed in Safety Action F)**	• The first Integrated Maternity and Neonatal Workforce Report, incorporating workforce establishment, staffing levels, vacancies, rota gaps and capacity risks across midwifery, obstetric,

In progress & on track	Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.	neonatal, anaesthetic and perioperative services, is scheduled for presentation to MNOG in September 2026. • Following review at MNOG, the report will be escalated through the Trust governance structure via the GCQ to provide assurance to the Trust Board regarding workforce and capacity risks and the actions being taken to mitigate these. • Following this initial submission, the integrated report will become the Trust's formal bi-annual workforce assurance report, replacing the existing midwifery staffing report and providing a single, multidisciplinary overview of workforce capacity, risks, trends and compliance with national standards across maternity and neonatal services.

Safety Action B: Training

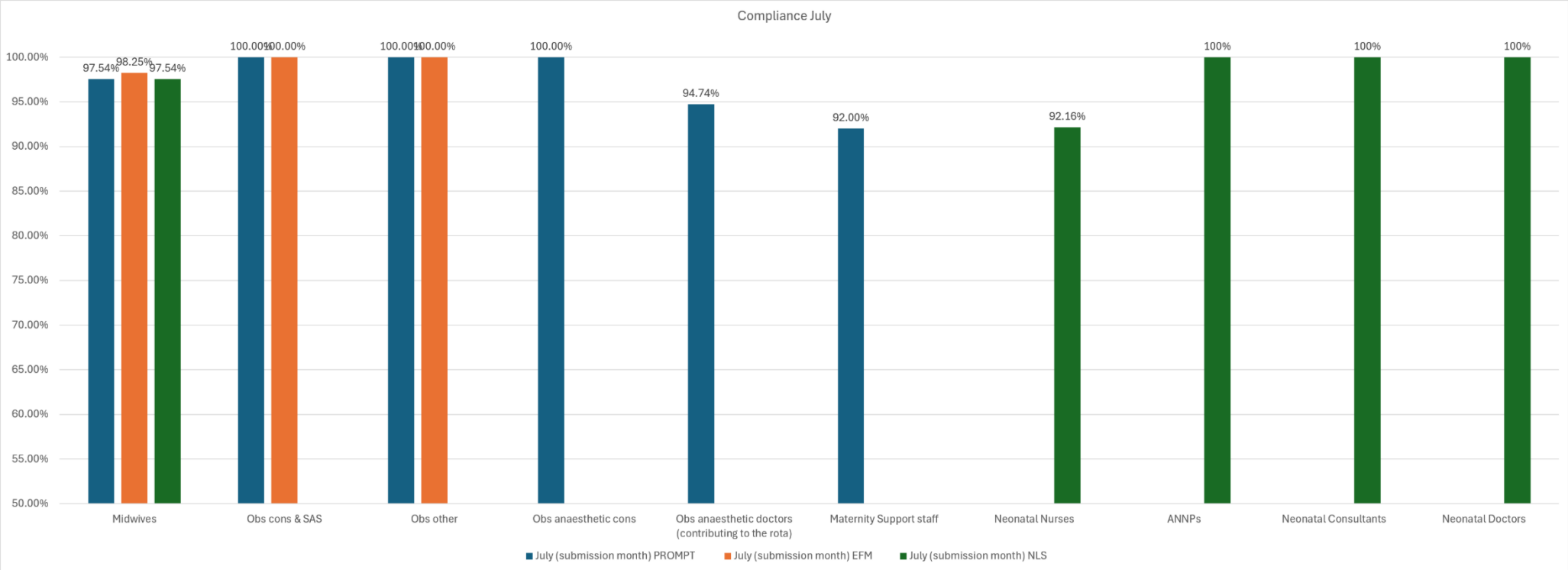
Sub-action reference	Sub-action description	Detail
B1 **Compliance risk**	**Obstetric emergency training** Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness. Anaesthetists working in maternity are required to attend at least half of	**August update:** • The service has achieved compliance with all staff groups and training requirements at the midway touchpoint for July. • The next submission point is the end of November. • Delivery plans are now in place which, subject to staff attending scheduled sessions, would enable the Trust to meet the 90% compliance threshold across all staff groups. Neonatal nurses and neonatal consultants will require additional ad hoc training sessions to support delivery of this target. • This represents a strong and improved position; however, there remains a material delivery risk. Historically, a proportion of non-attendance is unavoidable due to sickness and staff

	the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input (e.g. Postpartum haemorrhage (PPH)), escalation pathways, call chains, teamwork, communication and human factors are rehearsed. Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 (November 2026) as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training.	redeployment to maintain clinical services. While mitigation is in place, small cohort sizes in some staff groups mean that one or two non-attendances could result in compliance falling below 90%. • In addition, the Midwifery Education Team has direct oversight only of midwifery and support staff rosters and is not routinely informed when neonatal, anaesthetic, or obstetric staff are removed from training commitments. This limits real-time oversight, recovery planning, and timely rebooking. • Training compliance therefore remains a significant risk to achieving CNST this year. Achievement of the 90% standard is dependent on training being protected, sessions being attended as planned, and minimal redeployment from booked training. • Board support is requested to reinforce training as a priority across all services and to ensure this message is consistently applied in operational decision-making over the coming months. **Impacted fetal head training:** • In preparation for implementation of the Avoiding Brain Injury in Childbirth (ABC) programme, a brief update relating to the management of Impacted Fetal Head (IFH) has been incorporated into the PROMPT curriculum since April 2026. This has ensured staff are introduced to the principles of IFH in advance of the formal ABC programme rollout. • In addition, dedicated IFH training sessions aligned to the proposed ABC methodology have commenced, targeting obstetricians, labour ward co-ordinators and core labour ward staff to support early adoption of the approach and build local capability. • Further expansion of training is planned, with full integration of ABC-aligned IFH training into the 2027/28 PROMPT programme, ensuring ongoing multidisciplinary training and sustainable implementation across maternity services.
B2 **Compliance risk**	**Neonatal resuscitation** As a minimum, trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where	

	further enhanced training is in place for additional staff groups, this should continue (e.g. NLS (Newborn Life Support) Course or equivalent).	
B3 **In progress & on track**	**Fetal monitoring training** Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.	
B4 **In progress & on track**	**In situ multi-professional perinatal emergencies simulations** Trusts must deliver at least two in-situ multiprofessional perinatal emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g. labour ward, obstetric theatre, triage, ED, NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include	• The Trust is compliant with this requirement and has exceeded the minimum expectation of two in-situ multiprofessional perinatal emergency simulations during the reporting period. • Hospital-based emergency simulations are now embedded as business-as-usual practice and are undertaken across maternity and neonatal areas when clinical acuity allows. These simulations involve the relevant multidisciplinary teams, provide opportunities to rehearse escalation pathways, and generate learning that is shared through established governance and education forums. • In response to the enhanced MIS Year 8 requirement, community-based emergency scenarios have been incorporated into the emergency simulation programme. At least one community-initiated emergency simulation has already been completed during the reporting period, with learning captured and shared to support service improvement.

	real time practice of escalation pathways.	
B5 **In progress & on track**	**Training compliance oversight (as detailed in Safety Action F)** Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using Statistical Process Control (SPC) charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout the following year.	• Training compliance for all maternity and neonatal staff groups is routinely monitored and reported bi-monthly through established governance routes. Compliance data is presented monthly via maternity dashboards, providing clear visibility of performance and trends over time. • Training compliance is monitored against an agreed trajectory towards 100 percent, with a focus on achieving and maintaining ≥90 percent compliance across subsequent reporting periods. Reporting methods based on anticipated compliance are used to support effective oversight and early identification of risk. • Oversight and assurance are provided through formal governance structures, with any areas of concern or non-compliance escalated via the Perinatal Quality Oversight Meeting (PQOM) to ensure timely action and Trust Board awareness.

Training compliance: Trust selected checkpoint (July 2026)



Safety Action C: Learning from reviews and investigations

Sub-action reference	Sub-action description	Detail
C1 **In progress and on track**	**Notify all qualifying events** All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis.	• During the current reporting period, all relevant cases have been reviewed and confirmed to have been appropriately notified in line with national requirements.
C2 **In progress and on track**	**Seek parents' views of care** For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.	• During the current reporting period, for all relevant cases, parents have been given multiple opportunities to provide their experiences.
C3 **In progress and on track**	**External multi-disciplinary reviewers** For a minimum of 60% of the deaths reviewed, external members of relevant specialties	• During the current reporting period 71% of deaths reviewed had external members of relevant specialties present at the multi-disciplinary review, and this is documented within the PMRT.

	must be present at the multi-disciplinary review, and this should be documented within the PMRT	
C4 **In progress and on track**	**Provide relevant information** Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	• During the current reporting period, the Trust is able to demonstrate 100% compliance in providing relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour has been provided for 100% parents.
C5 **In progress and on track**	**Offer parents a meeting with relevant specialists** Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	• This requirement represents a new element introduced in CNST ensuring a consistent and family-centred approach to sharing the outcomes of reviews and investigations. • Locally, processes are in place to ensure that parents are routinely offered the opportunity to meet with relevant specialists to discuss findings arising from reviews, investigations, and associated incident reports. This includes: o A postnatal debrief clinic offer for all families who have experienced bereavement o A tripartite meeting offer for all MNSI investigations o An offer of a meeting with the multidisciplinary team following publication of reports from After Action Reviews (AAR) and/or MDT reviews
C6 **In progress**	**Thematic reports of learning and actions**	• A quarterly Learning and Actions Thematic Report template was shared at MNOG in July 2026 and agreed for future use in line with CNST MIS Year 8 Safety Action C to triangulate learning from PMRT, MNSI, PSII, risk management and NHS Resolution processes into a single assurance report.

and on track	The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training	• A retrospective Quarter 1 report will be presented to September MNOG following approval of the reporting template.

Safety Action D: Service-user voice and equity

Sub-action reference	Sub-action description	Detail
D1 **In progress and on track**	**Communication equity, language support and accessible information** Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.	• Inequalities dashboard review now complete and for presentation at MNOG in September prior to sharing with GQC and Trust Board in line with the 10-Point Plan for Maternity and Neonatal services.
D2	**Service-user voice driving safety and quality improvement**	• Inequalities dashboard review now complete and for presentation at MNOG in September prior to sharing with GQC and Trust Board in line with the 10-Point Plan for Maternity and Neonatal services.

In progress and on track	Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service. Progress with this work should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.	• CIVICA still not launched within Maternity however Consultant Midwife has proposed a move to a more robust maternity patient experience framework which aims to move towards a continuous maternity intelligence model which will incorporate every compliment, concern, story, complaint and FFT (via CIVICA) response to align with NHSE Maternity and Neonatal 10 Point Plan in order to create a single maternity patient experience dataset to as to capture, analyse and responding to patient experience feedback from all maternity settings ensuring that women's voice directly influence quality improvement, service development and safety learning and that there is a "closed loop" process for response to feedback. • The proposal aims to utilise Matrons, Managers, Specialist Team Leads and Patient Experience Champions within the ward areas in order to keep patient experience a priority.

Safety Action E: Care bundles

NHSR Assurance visit-formal feedback:

The review team described the Trust as exceptionally well prepared, open, reflective and improvement-focused, highlighting the strong commitment of both leaders and frontline teams to improving outcomes for women, babies and families. They were particularly impressed by the positive culture, multidisciplinary working, and the respectful relationships evident across teams.

Key strengths identified included:

- Strong Board oversight and governance arrangements.
- Effective use of data, audit findings and local safety intelligence to drive improvement.
- A mature approach to assurance, scrutiny and organisational learning.
- Openness and honesty when discussing challenges and areas still under development.
- Strong multidisciplinary engagement across maternity, neonatal and wider services.
- Innovative smoking cessation work, which reviewers highlighted as particularly noteworthy.
- Robust internal assurance processes involving Corporate Compliance colleagues.

Safety Action E1 (Saving Babies' Lives Care Bundle) was assessed as Fully Met, with reviewers recognising strong governance, effective use of audit and performance data, and demonstrable improvements, particularly in smoking cessation.
Safety Action E2 (Maternal Care Bundle) and E3 (Neonatal Pulse Oximetry Screening) were assessed as Mostly Met. Reviewers acknowledged the significant progress made, strong planning, multidisciplinary collaboration and governance oversight, noting that the remaining gaps related primarily to approval and governance processes rather than concerns regarding implementation or leadership.

The review also highlighted a number of examples of good practice that may be useful to share more widely across the scheme, including the Trust's internal assurance processes, integration between maternity, governance and Board structures, use of local safety intelligence, and culture of openness and continuous improvement.

Overall, reviewers concluded that the Trust has a strong, transparent and well-established approach to maternity governance and assurance, and is on a credible trajectory towards full compliance with CNST MIS Year 8 requirements. The full report is available in appendix one.

Sub-action reference	Sub-action description	Detail
E1 **In progress and on track**	**Saving Babies' Lives Care Bundle (SBLCBv3.2) Quarterly reporting to the Trust Board**	• The Trust has now achieve 100% compliance with SBLCBv3.2 with progress demonstrated through the new quarterly reports.

	The provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the SBLCB based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents. In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to fetal growth restriction (FGR) detection as highlighted.	
E2 **In progress and on track**	**Maternal Care Bundle – Implementation Plan** In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the	• Following a period of national ambiguity regarding the scope and expectations of the MCB, recent clarification from NHS England and NHS Resolution has confirmed that organisations are expected to both secure Trust Board approval of an implementation plan (CNST MIS requirement) and achieve full implementation of all MCB components (national requirement) by March 2027.

	Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.	• While the Trust is well positioned to meet the CNST MIS requirement relating to organisational planning, governance, and assurance requirements associated with the MCB, the scale of operational change, workforce implications, system dependencies, and resource requirements currently identified indicate that full implementation is unlikely to be achieved by March 2027 • Trust Board proposal paper for the oversight and assurance process for the MCB has been shared and agreed in principle with the Group Chief Nurse and the Group Chief Clinical Governance Officer pending agreement from Trust Board (Appendix two). • The implementation plan will be shared at MNOG in September, GQC in October and to Trust Board in November.
E3 **In progress and on track**	**Neonatal pulse oximetry testing** Trusts must develop a standardised, equitable, and governance approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between 2 and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.	• The guideline has now been approved through Neonatal Governance and is scheduled for review at Maternity Guideline Group prior to publication. • A communication and education programme is planned to support implementation across all settings. • A programme of audit and evaluation has been established, with compliance and effectiveness to be monitored at 1, 3, 6 and 12 months post-implementation through existing governance arrangements, providing ongoing assurance of uptake and adherence to the standard.

Safety Action F: Board oversight, governance, culture and leadership

Sub-action reference	Sub-action description	Detail
F1 **In progress and on track**	**Board Oversight of Maternity and Neonatal Quality and Safety** Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles at the frequencies outlined in Safety Actions A–E. Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee (or equivalent) are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). Where Trust level mitigation to concerns is insufficient, escalation to Regional Midwifery Officer teams should be	• Progress against the six safety actions is monitored through the bi-monthly Maternity and Neonatal Oversight Group (MNOG), which provides structured oversight of delivery, performance, quality improvement and risk, including detailed review of data and evidence to assure MIS compliance. • MNOG is chaired by the Director of Nursing (Executive Sponsor and Board Maternity Safety Champion) and attended by the NED Maternity Safety Champion, ensuring strong executive accountability alongside independent challenge. • Key outputs, including assurance ratings, risks and escalations, are reported to the Group Quality Committee (GQC), a formal sub-committee of the Trust Board, which provides robust scrutiny and oversight of maternity and neonatal quality and safety. • Governance arrangements have been strengthened to support Year 8 MIS requirements, with clearly defined internal pathways to ensure appropriate Trust Board review and formal sign-off. • In response to reduced ICB assurance, the Trust has enhanced its internal assurance processes, with MNOG providing subject matter oversight and GQC confirming that compliance is embedded within the wider governance framework. • This is supported by the Corporate Compliance Team, who will undertake structured evidence reviews at defined checkpoints to ensure accuracy, completeness and consistency before final submission to the Trust Board for approval and declaration.

	documented, alongside PQOM aligned actions.	
F2 **In progress and on track**	**Maternity Outcomes Signal System** Trusts must evidence that the critical safety check (Annex 1 of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill (Annex 9) was carried out if no signals occurred. An accountable trust board executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance - services must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.net	• The Trust has established a draft SOP and assurance process to demonstrate compliance with MOSS requirements. • Critical Safety Checks (CSC) have been completed for all signals to date with outputs formally reviewed and approved by the Group Chief Nurse, with evidence submitted for regional validation. • Oversight is provided through the bi-monthly Maternity and Neonatal Oversight Group (MNOG), chaired by the Group Chief Nurse and attended by the NED Maternity Safety Champion, with escalation to Quality Committee for Board-level scrutiny and assurance • Assurance is supported through confidential Executive Summaries for public Board reporting, with full detail available at Private Board
F3 **In progress and on track**	**Maternity and Neonatal Board Safety Champions** Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in	• MNOG is chaired by the Director of Nursing (Executive Sponsor and Board Maternity Safety Champion) and attended by Maternity Safety Champions including the Non-Executive Director ensuring strong executive accountability alongside independent challenge. • Strategic MNVP lead now in post and has attended and contributed to the the last two MNOG meetings

	line with MNVP guidance), in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board where any concerns are identified.	
F4 **In progress and on track**	**Perinatal Culture Improvement Plan** Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly	• Culture improvement work is ongoing, with regular progress updates, evaluation of impact, and emerging themes reported through the MNOG to ensure continuous oversight. • Plan is due for presentation at November MNOG

Conclusion:

The Trust remains on a strong trajectory towards achieving compliance with the CNST MIS Year 8 requirements. Progress is evident across all six safety actions, supported by strengthened governance arrangements, improving workforce positions, positive external assurance feedback, and continued delivery of key quality and safety improvement programmes.

Significant achievements during this reporting period include alignment with Birthrate Plus workforce recommendations, sustained progress against neonatal QIS trajectories resulting in removal of the associated Trust risk, achievement of Saving Babies' Lives Care Bundle requirements, and continued compliance with learning and review processes.

The principal residual risk remains achievement of the November 2026 multidisciplinary training compliance thresholds. Whilst current trajectories indicate compliance is achievable, delivery remains dependent upon training being prioritised operationally and staff being able to attend planned sessions. Focus during the remainder of the reporting year will therefore be on maintaining training compliance, embedding new

Year 8 requirements, progressing Maternal Care Bundle implementation planning, and ensuring continued Board oversight of quality, safety and workforce risks.

Subject to continued delivery of planned actions and sustained organisational support, the Trust remains well placed to achieve full compliance with the CNST MIS Year 8 scheme by the November 2026 reporting deadline.

Appendix

Appendix one: NHSR Assurance Visit Feedback ULTH 27082026
Appendix two: Trust Board Proposal for Oversight and Assurance of Maternal Care Bundle V1.1 11082026

Annexe

A1: Introduction

Following receipt of confirmation of full compliance with Year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), United Lincolnshire Teaching Hospitals (ULTH) Maternity and Neonatal services continue to progress Year 8 of the scheme. NHS Resolution (NHSR) launched Year 8 MIS on March 31st, 2026 with accompanying supplementary guidance following a 'Letter to Trusts' in February 2026 providing advanced notice of key changes to the scheme. The details and key changes to the MIS have now been benchmarked. The completed Board Declaration forms must be submitted between **16th February 2027** and by **12 noon** on **March 2nd, 2027,** with the reporting period ending on **30th November 2026.**

Year 8 introduces a streamlined set of six core safety actions enabling Trusts to focus on the areas that have the greatest impact on outcomes for their population. This shift reflects learning from previous years and responds to feedback from providers about the need to reduce duplication and process heavy activity. The intention is to support Trusts to concentrate on what matters most: securing the right workforce, learning from adverse events, improving clinical standards, strengthening culture, delivering better experiences for women, families and carers and supporting Trust flexibility while emphasising Board accountability and oversight.

A2: Background

Year 8 marks an important transition for the Maternity (Perinatal) Incentive Scheme (MIS). As national priorities for maternity and neonatal care continue to evolve, the scheme has been refreshed directly in response to the findings of our MIS evaluation, national inquiries, system feedback, and feedback directly from Trusts, staff and families. It recognises the significant pressures on services and the need to focus effort where it makes the greatest difference locally.

The focus this year is on strengthening the core elements of safe, effective care and making the scheme simpler through a model which is more principles based, outcomes focused and aligned with the needs of women, families and the workforce. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund.

A3: Reporting process

ULTH progress towards achieving the six safety actions is reported through the bi-monthly Maternity and Neonatal Oversight Group (MNOG), which provides structured oversight of delivery, performance, quality improvement and risk. MNOG undertakes detailed review of data, reports and supporting evidence to assure progress against the MIS requirements and the six safety actions.

MNOG is chaired by the Group Chief Nurse, who is also the Executive Sponsor and Trust Board Maternity Safety Champion, providing clear executive accountability. The Non-Executive Director (NED) Maternity Safety Champion also attends the group, strengthening independent challenge and Board-level assurance.

Output from MNOG, including assurance assessments, escalations and exceptions, are reported directly to the Quality Committee (QC), a sub-committee of the Trust Board with delegated authority for maternity and neonatal oversight. QC provides independent scrutiny, challenge and risk oversight, ensuring that quality and safety performance, including immediate priorities and areas of concern, are reviewed in depth and appropriately escalated.

Several elements of the MIS will require explicit Trust Board sign-off during Year 8, NHSR have provided clarification outlining the expectations, this has been defined locally to ensure governance routes are accurate and that compliance is achieved.

Term	MIS definition	ULTH agreement	
Trust Board	Full Trust Board or a formally delegated committee (Quality Governance Committee) acting on its behalf.	**Reading room into:** **Group Trust Board (public)** *Or* **Quality Committee (QC)** which is a sub-board committee with delegated authority for maternity and neonatal oversight	Detailed thematic reports may be reviewed by the Executive Board or Quality Governance Committee, but a summary including escalations and exceptions must be presented to the Trust Board to ensure full oversight.
Executive Board	Private or executive only meeting of Board members where sensitive, small number or	**Private Group Board**	

	confidential material (e.g. mortality themes) is more appropriately discussed.		

In the context of Integrated Care Boards (ICB) stepping back from their formal assurance role, the Trust has strengthened its internal governance and assurance arrangements to mitigate the risk associated with the removal of external scrutiny. MNOG will continue to play a central role in providing subject-matter assurance on MIS delivery, including oversight of compliance, review of supporting evidence, and assurance of the quality and completeness of submissions. This assurance will be escalated through the QC, which will confirm that MIS compliance is sustained and embedded within the Trust's wider quality and safety governance framework.

The assurance process will be supported by the Corporate Compliance Team with the addition of defined evidence review points throughout the period. The Corporate Compliance Team will ensure consistency and completeness of evidence and provide a formal compliance assessment. Following this review, the evidence will be presented to delegated members of the Trust Board for final scrutiny and approval prior to signing the Board Declaration.

Collectively, this strengthened internal governance route, encompassing the Maternity and Neonatal Oversight Group, Quality Committee, Corporate Compliance Team and Trust Board, provides a comprehensive and layered assurance framework, mitigating the removal of the additional assurance previously provided by the LMNC/ICB and ensuring continued accountability, transparency, and compliance in Year 8.

A4: Submission conditions

To be eligible for payment under the scheme, Trusts must achieve all six perinatal safety actions and submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12:00** on **2 March 2027** and must comply with the following conditions:

- The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with perinatal safety actions by the Perinatal Leadership Team, including the Maternity and Neonatal Voices Partnership (MNVP) Lead where MNVP arrangements exist.
- The Trust's CEO must sign to confirm that:
    - The Trust Board are satisfied that the evidence provided to them demonstrates achievement of the six core perinatal safety actions and meets the required safety actions' sub-requirements as set out in this document.
    - There are no reports covering either year 2025/26 or 2026/27 that relate to the provision of maternity and / or neonatal services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Health Services Safety Investigations Body (HSSIB) or MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 2 March 2027

  - Any reports covering an earlier time-period may prompt a review of a previous MIS submission.
  - If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.
- The Trust Board must then give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

A5: Additional assurance

- Trust submissions will continue to be sense-checked alongside Care Quality Commission (CQC) information. Where CQC visits fall within the reporting period, the CQC will cross-reference their findings to the MIS through the relevant Key Lines of Enquiry.
- Mid-year 'spot-check' (July/August)
  - Advisory only within year 8 and intended to help organisations ensure they remain on track to meet compliance requirements.
  - One Trust per region may be randomly selected to provide NHSR with a progress update against a randomly selected safety action.
  - NHSR will pilot additional alternative assurance approaches in 2026 with a small number of self-selected pilot trusts, including service-user and peer review models.

A6: Reporting requirements and frequency

Trusts are expected to:

- use evidence that is proportionate and meaningful
- rely on information that should already be being used for local and Board assurance
- focus on how safety actions are embedded in day-to-day practice all year round

Evidence should demonstrate how risks are identified and managed, how learning leads to improvement, and how Boards maintain oversight of maternity and neonatal safety.

Safety Action	Requirement	Reporting requirement	Frequency

SA: A Workforce and capacity	This safety action focuses on ensuring that maternity and neonatal services are safely staffed and sustainably resourced. Trusts are expected to have effective systems in place to plan, monitor and manage workforce and capacity across maternity and neonatal services, identify and escalate staffing risks, and ensure appropriate senior clinical presence. Strong workforce planning supports safe care, timely escalation and effective decision-making for women and babies.	Six-monthly integrated workforce report covering maternity and neonatal staffing levels, rota gaps, and temporary staffing.	At least every six months
SA: B Training	This safety action focuses on ensuring that staff have the skills, confidence and support needed to provide safe maternity and neonatal care. Trusts are expected to provide regular, multidisciplinary training that reflects local and national learning, and to maintain oversight of training participation through established governance routes. High-quality training supports teamwork, communication and effective responses in both routine and emergency situations.	Quarterly training compliance report for all maternity and neonatal staff groups, using trend-based data (SPC charts), monitored against a trajectory towards 100% compliance	Quarterly
SA: C Learning from reviews and investigations	This safety action focuses on how services learn when things go wrong, including reviews and investigations, and listening to families' experiences. Trusts are expected to have systems in place to identify and review qualifying events, involve parents and families meaningfully, and use learning to drive improvement and reduce the risk of harm. The emphasis is on learning, improvement and compassion, rather than blame.	Quarterly thematic reports summarising learning and progress on actions from reviews, investigations, and national reports. Must include demographic data to identify disparities	Quarterly
SA: D	This safety action focuses on ensuring that the voices of women, families and carers are heard, valued and acted upon, and that care is equitable.	Quarterly monitoring of progress with communication equity and service-user	Quarterly

Service-user voice and equity	Trusts are expected to capture and use feedback from women and families, understand the needs of their local population, and address barriers to safe, accessible and inclusive care. This includes recognising and responding to differences in experience and outcomes across different groups.	voice driving safety and quality improvement, using demographic data and feedback	
SA: E Care bundles	This safety action focuses on the implementation of national maternity and neonatal care bundles, which bring together evidence-based practices to improve outcomes. Trusts are expected to prioritise implementation based on local safety intelligence, monitor progress through established governance routes, and ensure Board-level oversight of care bundle delivery. This safety action emphasises the role of Trust Boards in leading and overseeing maternity and neonatal safety. They are ultimately accountable for ensuring safe perinatal services in their organisation. Trusts are expected to demonstrate that Boards receive clear, regular information on safety and quality, that risks are identified and escalated appropriately, and that leadership supports a positive safety culture. Effective Board oversight is crucial to ensure that learning leads to sustained improvement, and to facilitate appropriate Trust resource allocation. Care bundles support consistent, evidence-based care across services.	Quarterly Board reports on progress with Saving Babies' Lives Care Bundle (SBLCBv3.2), Maternal Care Bundle implementation plan, and neonatal pulse oximetry guideline	Quarterly
SA: F Board Oversight, governance,	This safety action emphasises the role of Trust Boards in leading and overseeing maternity and neonatal safety. They are ultimately accountable for ensuring safe perinatal services in their organisation.	Routine Board-level reports covering quality and safety, training, workforce, service-user experience, and care bundle progress. Escalation of risks and themes	As per A–E (minimum quarterly, some six-monthly)

culture and leadership	Trusts are expected to demonstrate that Boards receive clear, regular information on safety and quality, that risks are identified and escalated appropriately, and that leadership supports a positive safety culture. Effective Board oversight is crucial to ensure that learning leads to sustained improvement, and to facilitate appropriate Trust resource allocation.	from Quality Governance Committee to Executive Board	

United Lincolnshire Teaching Hospitals NHS Trust

Integrated workforce report

April 2026 – August 2026
Emma Upjohn- Director of Midwifery
V1.1 01/09/2026

Contents

Integrated workforce report 1
Executive Summary 2
Background 2
Maternity workforce establishment overview 3
Birthrate Plus review 3
Progress Against the Birthrate Plus Establishment Gap 4
Establishment overview 4
Obstetric workforce establishment overview 5
Establishment overview: LCH 5
Establishment overview: PHB 5
Consultant attendance 6
Short-term locum certification 6
Capacity to delivery planned and emergency care 7
Anaesthetic and perioperative workforce establishment overview 7
Lincoln County Hospital ..... **Error! Bookmark not defined.**
Pilgrim Hospital Boston ..... **Error! Bookmark not defined.**
Neonatal workforce establishment overview 8
Establishment overview: PHB (Special Care Baby Unit-SCBU) 8
Establishment overview: LCH (Local Neonatal Unit-LNU) 9
Workforce wellbeing 10
Sickness 10
Quality improvement 10
Key performance indicators 11
Supernumerary status of the labour ward co-ordinator 11
1:1 Care in labour 12
Midwife to Birth ratio 12
Maternity red flag report 12
Maternity escalation plan: mitigations and escalations for managing shortfalls 14
Conclusion 14
Annexe one: CNST MIS Year 8 Safety Action A Assurance Dashboard 15

Executive Summary

This report provides assurance regarding workforce establishment, staffing capacity, escalation processes and workforce-related risks across maternity and neonatal services, supporting compliance with CNST MIS Year 8 Safety Action A requirements. It demonstrates the Trust's continued commitment to ensuring safe, sustainable and responsive services through effective workforce planning, governance oversight and risk management.

Significant progress has been made during the reporting period. As of August 2026, the Trust has achieved a fully funded midwifery establishment aligned with the Birthrate Plus recommended requirement, reflecting a substantial organisational commitment to maternity workforce investment. Whilst a vacancy gap remains within the funded establishment, active recruitment and retention initiatives continue and have significantly reduced the original workforce deficit identified through the March 2024 Birthrate Plus review. Workforce performance, staffing risks and recruitment trajectories continue to be reviewed through established governance processes and Board reporting arrangements.

Neonatal nursing and medical workforce establishments remain aligned with BAPM recommendations, supported by ongoing workforce planning and monitoring arrangements. The Trust has maintained compliance with requirements relating to the engagement of short-term locum obstetric staff, with no short-term locums utilised during the reporting period. Appropriate controls remain embedded following previous learning to provide continued assurance regarding temporary staffing arrangements.

Safe staffing indicators continue to demonstrate positive performance, including sustained compliance with one-to-one care in labour and high levels of labour ward coordinator supernumerary status. Established escalation processes, daily operational oversight and multidisciplinary review mechanisms continue to support the safe management of workforce, acuity and capacity pressures across maternity and neonatal services.

Further work remains underway in relation to the audit of compliance with the RCOG *Roles and Responsibilities of the Consultant Providing Acute Care* standard and the review of planned caesarean birth capacity undertaken as part of CNST MIS Safety Action A6. The latter represents the first comprehensive assessment of planned caesarean birth capacity across the service and will provide an important baseline for future annual review, service planning and capacity management. Resulting actions will be incorporated into the Perinatal System Improvement Plan to ensure ongoing monitoring and delivery.

Overall, the report provides assurance that appropriate workforce planning, capacity management, escalation and governance arrangements are in place and that workforce-related risks are being actively monitored and mitigated to support the delivery of safe maternity and neonatal care

Background

Midwifery staffing reports have previously been presented to the Board on a bi-annual basis in line with the requirements of earlier CNST Maternity Incentive Scheme (MIS) years, with the last report submitted in May 2026 through established governance routes.

The introduction of CNST MIS Year 8 Safety Action A (Workforce and Capacity) places an increased emphasis on Board assurance regarding workforce establishment, staffing capacity, escalation processes, and the management of workforce-related risks across maternity and neonatal services. The Assurance Dashboard can be reviewed in annexe one.

This report provides an updated overview of the maternity and neonatal workforce, including establishment, vacancies, recruitment and retention, safe staffing metrics, and workforce risks. It also supports assurance against the requirements of CNST MIS Year 8 and the NHS England Maternity and Neonatal 10 Point Plan, which highlights the importance of safe, responsive services and effective workforce planning to improve outcomes for women, babies and families.

The report is presented to provide assurance that workforce risks are being appropriately monitored and mitigated and that the Trust continues to work towards delivery of national maternity and neonatal safety priorities.

Maternity workforce establishment overview

Birthrate Plus review

Birthrate Plus® (BR+) is the nationally recognised workforce planning tool used within maternity services to determine safe midwifery staffing establishments. The methodology is based on the total midwifery time required to provide care for women throughout the maternity pathway and supports the delivery of one-to-one midwifery care during established labour. It is endorsed by the Royal College of Midwives and remains a key component of CNST MIS requirements and national maternity workforce planning.

The Trust's most recent Birthrate Plus review identified a required establishment of 259.13 WTE across clinical, specialist and management midwifery roles, compared with a funded establishment of 247.03 WTE, resulting in a shortfall of 12.10 WTE. Recruitment to address this gap remains ongoing and, in May 2025, the Trust implemented a temporary uplift of 5.25 WTE midwives and 5.25 WTE Band 3 Maternity Support Workers while approval for the substantive establishment increase was progressed.

Although birth numbers have declined both locally and nationally, the complexity of women accessing maternity services continues to increase. Local case mix reviews have demonstrated a higher proportion of women within the most complex Birthrate Plus categories (Categories 4 and 5), reflecting increases in medical comorbidities, gestational diabetes, obesity, safeguarding concerns, perinatal mental health needs and induction of labour activity. This increase in acuity places additional demand on staffing resources despite a reduction in overall birth numbers.

The review found that funded specialist and management roles were broadly aligned with Birthrate Plus recommendations. However, a workforce gap remained within the clinical establishment, supporting the need for ongoing recruitment and retention initiatives to achieve the recommended staffing levels.

Since the completion of the original review, the Birthrate Plus methodology has undergone an independent national evaluation (2026). While the review concluded that Birthrate Plus remains a credible and valuable workforce planning tool, it highlighted that the methodology may not fully capture the increasing complexity of contemporary maternity care, including rising clinical acuity, safeguarding activity, perinatal mental health requirements, governance responsibilities and wider workforce pressures. Consequently, the findings of Birthrate Plus should be considered alongside local intelligence, quality indicators, safety metrics and operational pressures when determining workforce requirements.

The Trust continues to use Birthrate Plus as part of its wider workforce planning approach and undertakes regular establishment reviews to ensure staffing levels remain responsive to changes in activity, acuity and national expectations. Workforce establishment, vacancy levels, recruitment progress and safe staffing indicators are monitored through routine governance processes and are subject to regular review through maternity and neonatal operational and strategic oversight arrangements.

The next scheduled Birthrate Plus review for ULTH is due in early 2027. The review will provide an opportunity to reassess workforce requirements in the context of current birth activity, service configuration, case mix complexity, emerging national guidance and the evolving requirements of CNST MIS Year 8. Findings from the review will be used to inform future workforce planning, recruitment priorities and establishment requirements across maternity services.

Progress Against the Birthrate Plus Establishment Gap

The March 2024 Birthrate Plus review identified a required establishment of 259.13 WTE, compared with a funded establishment of 247.03 WTE, resulting in a workforce deficit of 12.10 WTE.

Since the gap was identified, the Trust has implemented a range of actions to mitigate risk and work towards full compliance with the recommended establishment. In May 2025, a temporary workforce uplift was approved, providing an additional 5.25 WTE midwives and 5.25 WTE Band 3 Maternity Support Workers while a substantive business case for the full establishment increase was progressed.

The substantive business case to fund the full 12.1 WTE Birthrate Plus establishment gap was initially submitted through the ICB Weighted Values Framework but was not approved. In response, the Trust recognised the workforce and safety implications of the identified shortfall and committed recurrent funding as a local cost pressure to support recruitment towards the recommended establishment. This included investment of approximately £450,000 to recruit additional Band 6 midwives, alongside the previously agreed temporary uplift, demonstrating the Trust's commitment to progressing the Birthrate Plus recommendations despite the absence of external funding approval. Recruitment into the approved uplift commenced in April 2026 and has been largely achieved, with vacancies significantly reduced and the remaining posts actively recruited to. This has been supported by ongoing investment in preceptorship, retention initiatives and workforce planning to maintain staffing resilience and support a workforce where almost half of staff have less than five years' service.

Recognising the potential risk associated with the staffing deficit, a formal risk assessment was completed and included on the maternity risk register. The risk continues to be reviewed through established governance processes alongside workforce metrics, acuity data, incident reporting and operational pressures.

Whilst recruitment into the substantive uplift has progressed, a number of interim mitigations have remained in place to ensure safe service delivery, including:

- Daily multidisciplinary safety huddles reviewing staffing, acuity and capacity across all maternity areas.
- Twice-weekly forward staffing reviews to identify and address emerging workforce risks.
- Use of the maternity escalation policy to manage staffing shortfalls and operational pressures.
- Redeployment of staff where clinically appropriate to maintain safety.
- Ongoing monitoring of staffing-related incidents and red flag events through governance arrangements.
- Senior operational oversight from matrons and the maternity leadership team.

These actions have supported the maintenance of safe maternity services during the recruitment period. Throughout the reporting period, there were no adverse maternal or neonatal outcomes directly attributed to midwifery staffing shortfalls, and staffing intelligence continued to be triangulated with patient safety reviews, incident reporting and quality metrics to provide assurance regarding the effectiveness of the mitigations in place.

As of August 2026, the Trust has achieved a fully funded midwifery establishment aligned to the Birthrate Plus recommended requirement. A vacancy gap remains within the funded establishment, and targeted recruitment and retention activity is ongoing to increase staffing in post. Workforce metrics and recruitment progress continue to be monitored through established maternity governance processes, the Maternity and Neonatal Oversight Group and Trust Board reporting arrangements.

Establishment overview

Staff group	Birthrate Plus recommended	Current funded establishment	Vacancy WTE
Midwives	259.13	259.13	-7.8

Specialist midwives & management roles	23.80	23.79	+.01
Senior Leadership Team	27.76	27.76	0
Healthcare support workers and Maternity Support Workers	65.91	65.91	-10.94
Sonographers	Not a current recommendation in BR+		

Obstetric workforce establishment overview

Unlike midwifery staffing, there is currently no equivalent nationally recognised tool for determining obstetric medical staffing establishments. As a result, obstetric workforce planning remains largely dependent on local assessment of service demand, workforce capacity, training requirements, workforce sustainability and emerging national recommendations. In the absence of national standards, the Trust reviews obstetric workforce capacity and establishment requirements on a monthly basis against service activity, workforce availability, operational pressures and national maternity safety expectations.

Obstetric workload continues to increase as a result of rising clinical complexity, enhanced safety and governance requirements, increasing maternity triage activity, growth in high-risk care pathways, and increased rates of intervention, including induction of labour and elective caesarean birth. These factors have increased demand on both consultant and resident doctor capacity. The combination of increasing clinical acuity, evolving service models, enhanced safety requirements and greater public, regulatory and professional scrutiny has resulted in a more resource-intensive obstetric service, requiring ongoing review of medical workforce capacity to ensure it remains aligned with service demand.

Whilst midwifery services have received establishment uplifts informed by Birthrate Plus reviews, there has been no equivalent nationally recognised methodology or associated investment for obstetric staffing. The Trust therefore continues to monitor capacity closely and utilise local activity, quality and workforce data to inform future workforce planning. Further work to map service demand and workforce requirements may support development of a future business case for obstetric workforce growth.

Establishment overview: LCH

Overall WTE	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Budgeted WTE	36.78	36.78	36.78	36.78	36.78	36.78	36.78
Tier 3	12.78	12.78	12.78	12.78	12.78	12.78	12.78
Tier 2	-	-	-	12.00	12.00	12.00	12.00
Tier 1	24.00	24.00	24.00	12.00	12.00	12.00	12.00
Substantive WTE	40.34	39.34	38.34	38.74	38.28	38.28	38.28
Tier 3	13.00	13.00	12.00	11.00	10.89	10.89	10.89
Tier 2	-	-	-	13.74	13.39	13.39	13.39
Tier 1	27.34	26.34	26.34	14.00	14.00	14.00	14.00
Agency WTE	1.80	1.77	1.53	1.83	1.96	0.90	1.63
Bank WTE	2.32	1.26	2.75	3.25	1.08	2.06	0.89

Establishment overview: PHB

Overall WTE	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Budgeted WTE	26.00	26.00	26.00	26.00	26.00	26.00	26.00
Tier 3	9.00	9.00	9.00	9.00	9.00	9.00	9.00
Tier 2	1.00	1.00	1.00	8.00	8.00	8.00	8.00
Tier 1	16.00	16.00	16.00	9.00	9.00	9.00	9.00
Substantive WTE	27.06	27.06	27.06	25.30	25.30	25.30	27.30
Tier 3	10.00	10.00	10.00	10.00	10.00	10.00	10.00
Tier 2	2.00	2.00	2.00	10.84	10.84	10.84	10.84
Tier 1	15.06	15.06	15.06	4.46	4.46	4.46	6.46

Agency WTE	-	-	-	-	-	-	-
Bank WTE	4.75	6.07	5.44	5.08	3.85	3.15	3.20

Consultant attendance

Consultant attendance is monitored in line with CNST MIS requirements and the Trust's Clinical Escalation in Obstetrics and Gynaecology Guideline. The guideline sets out specific clinical situations where consultant attendance is mandatory, alongside clear escalation processes to support timely senior review and decision-making.

Compliance is monitored through consultant attendance audit. At each obstetric handover, the outgoing resident doctor completes a consultant attendance log, which is reviewed by Labour Ward Leads. Any instances of non-attendance or delayed attendance are investigated, with actions implemented where required. Findings are reported through maternity governance processes and form part of routine Board assurance regarding the safety and responsiveness of obstetric services.

The Trust has consistently achieved compliance with CNST consultant attendance requirements in previous reporting years, demonstrating robust arrangements for senior obstetric oversight and escalation. The Trust's escalation policy provides clear arrangements for contacting on-call consultants, obtaining second consultant support when required, and escalating concerns where immediate consultant attendance is needed, ensuring effective consultant involvement in the management of complex or emergency maternity care.

Short-term locum certification

The Trust has processes in place to support the safe engagement of short-term locum obstetric medical staff. Historically, the use of short-term locum doctors within obstetrics and gynaecology has been minimal, with rota gaps primarily covered through internal locum shifts undertaken by doctors already working within the service. During the CNST MIS Year 6 reporting period, the Trust identified a single instance of non-compliance relating to the engagement of a short-term locum registrar. Although the doctor concerned was a consultant on the specialist register and had undergone the Trust's standard recruitment and approval processes, subsequent review established that the individual did not meet the specific CNST and RCOG requirements regarding recent NHS experience. The issue arose following an oversight within the external recruitment agency's compliance process, which failed to identify that the doctor's most recent NHS experience did not meet the required standard.

Following investigation, additional controls were implemented across the recruitment agency, Trust recruitment team and maternity service, including strengthened compliance checks, revised locum approval processes, enhanced consultant guidance and additional staff training. The case also highlighted a wider national issue regarding the interpretation and application of the CNST short-term locum requirements for doctors on the GMC Specialist Register undertaking middle-grade locum shifts. The matter was formally escalated to NHS Resolution and the master vendor recruitment agency for review. As a result, the recruitment agency introduced a number of changes to its national compliance processes, including enhanced verification of recent NHS experience, revisions to registration and eligibility checklists, additional recruiter training, and greater transparency regarding a doctor's previous NHS employment history and compliance status. This learning was shared more widely across recruitment partners and contributed to strengthening assurance processes for the engagement of short-term locum doctors, both locally and nationally.

During the current reporting period, obstetric rota gaps have continued to be managed through internal locum arrangements undertaken by substantive doctors already working within the service. No external short-term locum doctors have been utilised during this period. Assurance arrangements established following the Year 6 review remain embedded within Year 8 and include ongoing oversight of locum utilisation, recruitment processes, workforce governance and medical staffing metrics. Collectively, these provide assurance that temporary staffing is used safely, appropriately and only where necessary to maintain service continuity and patient safety.

Capacity to delivery planned and emergency care

Multidisciplinary meetings between the midwifery and obstetric teams continue to review planned caesarean birth activity, capacity and patient flow across both maternity sites. This work has been progressed in response to CNST MIS Safety Action A6 and represents the first comprehensive review of planned caesarean birth capacity undertaken across the service.

Data has now been collected and collated from both Lincoln and Boston, mapping the planned caesarean birth pathway from pre-operative assessment through theatre utilisation, recovery provision and postnatal bed capacity. Findings are currently being analysed and triangulated with workforce, operational and activity data to understand variation, identify constraints within the pathway and assess the alignment of available capacity with demand.

Whilst this review has not historically been undertaken in a systematic way, it will provide a valuable baseline assessment of current service provision and highlighted the importance of ongoing evaluation to support safe and effective service delivery. Increasing ELSCS capacity has been an ongoing focus for the service and remains reflected on the maternity risk register. Actions implemented to date, including improvements in planning, oversight and pathway management, have resulted in a reduction in the risk score; however, further work is required to ensure capacity consistently meets demand and supports optimal patient flow across both sites.

Recognising this, the review will now be incorporated into annual service planning arrangements, enabling regular assessment of planned caesarean birth activity, capacity requirements and emerging risks. This will support proactive workforce and resource planning, provide assurance that ELSCS capacity continues to be reviewed against demand, and support ongoing compliance with CNST expectations. The annual review process will also ensure that any capacity pressures, risks or opportunities for service improvement are identified and addressed in a timely manner through established governance structures.

A report detailing the findings, conclusions and recommendations is currently being developed and will be presented through the appropriate governance structures. Any resulting actions and improvement opportunities will be incorporated into the Perinatal System Improvement Plan (PeriSIP), with progress monitored through existing maternity governance processes to ensure sustained oversight and delivery.

Anaesthetic and perioperative workforce establishment overview

The Trust holds Anaesthesia Clinical Services Accreditation (ACSA), providing independent assurance that anaesthetic services meet the Royal College of Anaesthetists' national standards, including ACSA Standard 1.7.2.1 relating to obstetric anaesthetic provision. This standard requires a duty anaesthetist to be immediately available to the obstetric unit 24 hours a day and, where additional clinical responsibilities exist, that arrangements are in place to allow obstetric care to take priority and for non-obstetric responsibilities to be delegated as required. Perioperative staffing requirements are additionally managed through established theatre workforce planning and operational governance arrangements to ensure safe delivery of elective and emergency maternity care.

Achievement and maintenance of ACSA accreditation demonstrates that the Trust has evidenced compliant rota arrangements, appropriate consultant and resident anaesthetic cover, clear escalation procedures, staff induction processes, and ongoing audit and monitoring arrangements. This includes assurance that suitably trained anaesthetic staff are available 24/7 to support labour ward activity, emergency and elective obstetric procedures, and regional analgesia services, with systems in place to ensure timely response to urgent obstetric requirements. The Trust has also demonstrated compliance with the corresponding CNST Maternity Incentive Scheme requirements relating to obstetric anaesthetic availability and workforce capacity in previous reporting years. Ongoing monitoring through ACSA accreditation processes, CNST assurance submissions, workforce governance arrangements and rota oversight provides continued assurance that anaesthetic staffing remains safe, responsive and aligned with national standards.

Across both maternity sites, obstetric services are supported by dedicated anaesthetic and perioperative workforce arrangements that provide 24/7 access to anaesthetic expertise, senior escalation and theatre support for elective and emergency maternity care. A suitably trained Operating Department Practitioner (ODP) is available at all times to support obstetric theatre activity, including elective and emergency caesarean births. Consultant anaesthetic support is available 24 hours a day, with established escalation arrangements in place to ensure timely senior clinical input when required.

Lincoln County Hospital

- The on-call Consultant Anaesthetist (08:00-18:00) is job planned Monday to Friday.
- A middle-grade anaesthetist (08:00-20:30) is job planned seven days per week.
- Overnight middle-grade cover (20:00-08:30) is job planned, with gaps occurring on four nights in every eight-week rota cycle, supported through established cover and escalation arrangements.
- Elective caesarean section lists are scheduled Tuesday to Friday mornings.

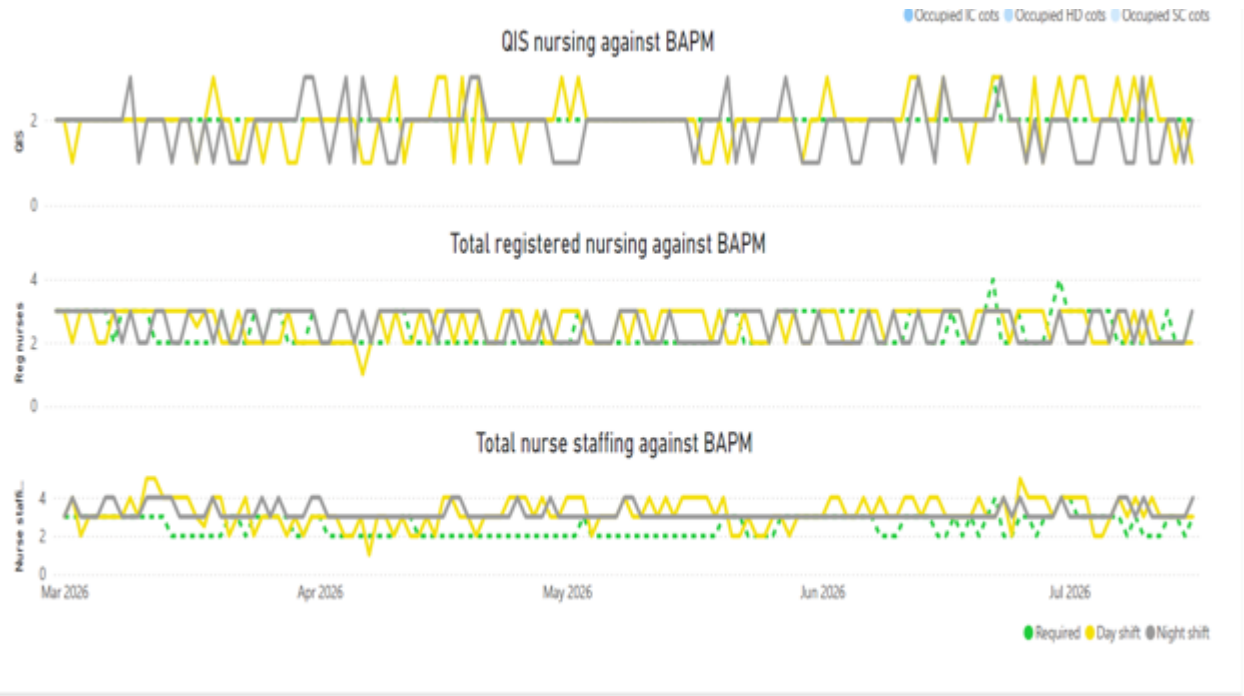
Pilgrim Hospital Boston

- A dedicated Obstetric Consultant Anaesthetist (08:00-18:00) is job planned on Monday, Tuesday and Thursday.
- A middle-grade anaesthetist (08:00-20:30) and overnight middle-grade cover (20:00-08:30) are job planned seven days per week.
- Elective caesarean section activity is scheduled on Wednesday (all day) and Friday morning, with additional consultant provision supporting elective activity through programmed or extra-duty sessions as required.

Neonatal workforce establishment overview

Establishment overview: PHB (Special Care Baby Unit-SCBU)

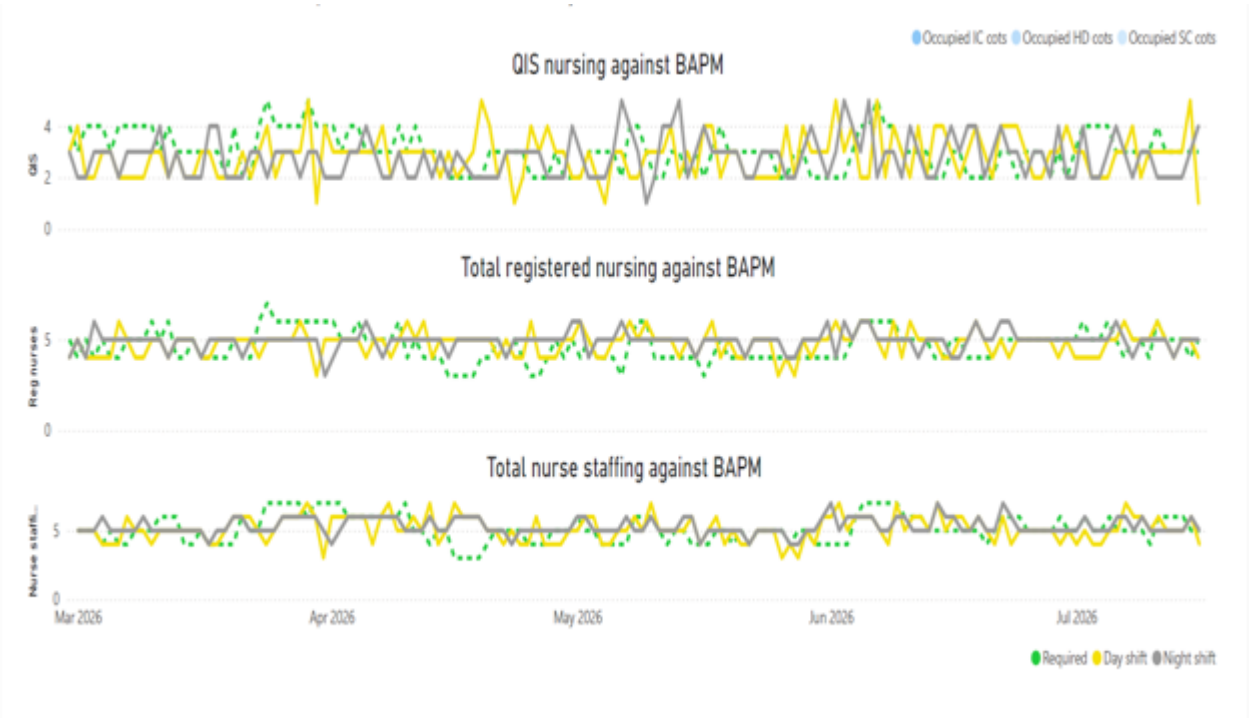
Nursing workforce	Establishment (WTE)	In post (WTE)	Vacancy WTE
Qualified in Speciality	11.79	10.56	-1.23
Nurses	15.18	13.95	-1.23
Support staff	5.26	5.41	-8.69
Nursing Associates	0.8	0.8	0
Specialist nurses	0.6	0.6	0
Leadership	1.3	1.3	0
Transitional care	See LCH		



Medical workforce	Establishment (WTE)	In post (WTE)	Vacancy WTE
Tier three: Consultants			
Tier two: Middle grade			
Tier one: (ST1-3/GPVTS/F2)			
ANNP	**0**	**0**	**0**

Establishment overview: LCH (Local Neonatal Unit-LNU)

Nursing workforce	Establishment (WTE)	In post (WTE)	Vacancy WTE
Qualified in Speciality	17.54	14.26	-3.28
Nurses	23.54	20.26	-3.28
Support staff	10.52	4.92	-5.6
Nursing Associates	2.76	2.76	0
Specialist nurses	5.3	5.1	-0.2
Leadership	1.3	1.3	0
Transitional care	5.26	5.26	0



Medical workforce	Establishment (WTE)	In post (WTE)	Vacancy WTE
Tier three: Consultants			
Tier two: Middle grade			
Tier one: (ST1-3/GPVTS/F2)			
ANNP (cover Tier one)	8.44	7.44	-1
Trainee ANNP	1	1	0

Workforce wellbeing

Sickness

Staff group	Rate	Detail/mitigation
Midwifery	4.03%-5.15% against target of <4.3%	
Obstetric		
Neonatal (nursing and medical)		
Anaesthetic		

Quality improvement

Review of Internal Resource Deployment

A review has been undertaken of internal resource deployment, particularly in relation to roles that are not directly supporting frontline clinical care. This includes consideration of specialist and leadership posts and the balance between operational requirements, quality improvement activity, statutory responsibilities, and direct clinical provision. Where possible, specialist midwives maintain clinical competence and contribute to frontline activity, while ensuring delivery of essential safety, governance, education, public health, and quality functions. Workforce planning continues to assess the optimal deployment of resources to ensure that staffing remains aligned to service demand and patient safety requirements.

Management of Specialist Midwife Absences

The absence of specialist midwives presents a potential risk to the delivery of key programmes of work and the support available to clinical teams. Mitigating actions include cross-cover arrangements between specialist roles where appropriate, support from the wider leadership team, prioritisation of essential functions, and temporary redistribution of responsibilities. Clinical midwifery managers and matrons provide operational oversight to ensure that both frontline service delivery and critical specialist functions continue during periods of planned or unplanned absence. Any prolonged vacancies or absences are monitored through the maternity workforce meetings and escalated where required.

Community and Homebirth Service Provision

Ongoing work continues to review the sustainability of community and homebirth service provision in the context of workforce availability, demand, and service requirements. Staffing levels are regularly assessed to ensure equitable deployment across inpatient and community settings while maintaining safety as the primary consideration. Where workforce pressures arise, services may be adapted in line with local escalation processes to protect safe care across the maternity pathway.

Community Oversight Group

The Community Oversight Group provides oversight of community maternity services, including workforce capacity, demand, service performance, and the sustainability of community and homebirth provision. The group reviews staffing levels, caseloads, vacancies, sickness absence, and escalation concerns to ensure that resources are deployed appropriately and that community services remain safe and effective.

Through regular monitoring and escalation processes, the Community Oversight Group provides assurance that community and homebirth services are delivered within available staffing resources while maintaining quality, safety, and experience for women and families.

Maternity Triage

The National Maternity Triage Specification has now been released, and the service is undertaking the initial assessment tool to benchmark current compliance against the national standards. The regional team has advised that completion of the assessment will generate an overall percentage compliance score, which is required to be submitted alongside a local 10-point action plan by 25 September. The assessment will provide an opportunity to identify areas of good practice and any gaps requiring further development, including consideration of workforce, operational, and service delivery implications. A full benchmarking submission against the National Maternity Triage Specification is required in October, with progress monitored through established maternity governance and workforce oversight processes. Initial review has not identified any immediate concerns regarding the ability to meet the assessment requirements, and any actions arising will be incorporated into ongoing service improvement and workforce planning activity.

Key performance indicators

Supernumerary status of the labour ward co-ordinator

The supernumerary status of labour ward coordinators is another critical metric. ULTH has achieved near-total compliance, with occasional deviations due to workload demands. Any instances where supernumerary status was lost are investigated to ensure that labour ward coordinators were not providing 1:1 care to a woman in labour. This provides assurance patient care was not compromised.
When there is no labour ward coordinator available to coordinate, the service implements a series of measures to ensure safe and effective service continuity. This includes but is not limited to:

- reallocation of staff across areas based on clinical need
- requesting additional cover through the site team or bank where necessary

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

Metric	Benchmark			Data Source/ Standard	Link to Tab	Apr-26	May-26	Jun-26	Jul-26
	R	A	G						
Co-ordinator Supernumerary	<100%		100%	Inpatient Matron/CNST	Co-ordinator	98.87%	97.36%	98.68%	98.77%

1:1 Care in labour

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

Metric	Benchmark			Data Source/ Standard	Link to Tab	Apr-26	May-26	Jun-26	Jul-26
	R	A	G						
1-1 in labour	<100%		100%	BN/CNST	1-1Labour	100.00%	100.00%	100.00%	100.00%

Midwife to Birth ratio

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

Metric	Benchmark			Data Source/ Standard	Link to Tab	Apr-26	May-26	Jun-26	Jul-26
	R	A	G						
Midwife to Birth Ratio (funded)	01:27		01:26			01:26	01:26	01:26	01:26
Midwife to Birth Ratio (Actual)	01:27		01:26			01:24	01:25	01:25	01:26

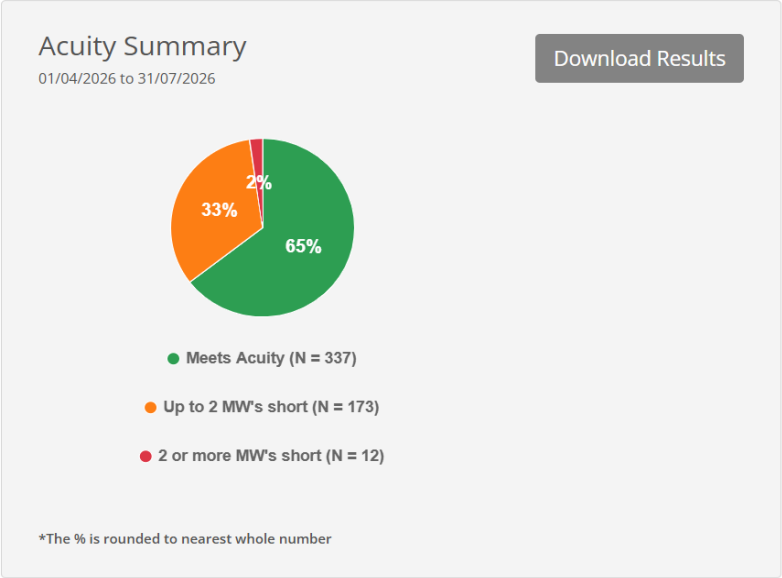
Maternity red flag report

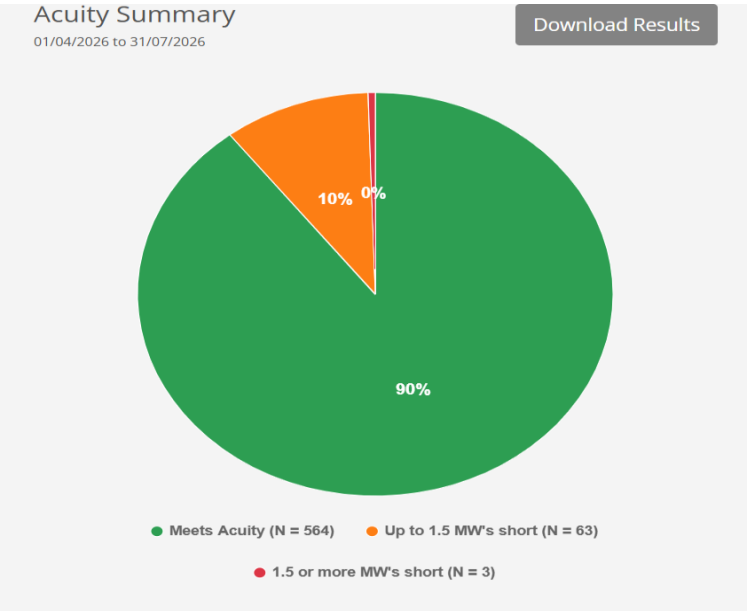
Acuity data is recorded using the Birth-Rate Plus tool. Workload and staffing information is input by the Labour Ward Coordinator every four hours (+/- 30 minutes) as a standard requirement. Ad-hoc entries can be submitted out with the set times and allow the Labour Ward Coordinator to input information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

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

The following data shows acuity information for the period April – July 26 and includes all data entries.

Bardney Lincoln Labour Ward – 1/4/26 to 31/07/26





Pilgrim Labour Ward 01/04/26 to 31/07/26

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

Pilgrim hospital's results for the period April 26 to July 26 showed that they were green, on average, 90% of the time, amber 10% and red 0% of the time. This is an improved picture to previous reports.

Lincoln hospitals result for the same period showed that they were green 65% of the time – a huge increase from the last reporting period amber 33% and red 2% of the time.

Maternity escalation plan: mitigations and escalations for managing shortfalls

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

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

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

Conclusion

The achievement of a fully funded midwifery establishment aligned with Birthrate Plus recommendations marks a significant milestone and provides a strong foundation for continued workforce sustainability. Whilst recruitment to the remaining vacancies remains a priority, the trajectory of improvement and mitigations in place provide assurance regarding the safety and resilience of current service delivery.

Workforce capacity, staffing risks and operational pressures continue to be subject to regular review through multidisciplinary operational processes, the Maternity and Neonatal Oversight Group and Trust Board reporting arrangements. These established mechanisms ensure that emerging risks are identified early, appropriately escalated and managed in a timely manner.

Looking ahead, key priorities include completion of the planned Birthrate Plus review, continuation of recruitment and retention initiatives, conclusion of the consultant attendance audit and implementation of actions arising from the planned caesarean birth capacity review. Together, these initiatives will support ongoing compliance with CNST MIS Year 8 Safety Action A requirements and strengthen the Trust's ability to deliver safe, effective and sustainable maternity and neonatal care.

The Board is therefore asked to note the contents of this report and take assurance that appropriate arrangements are in place to monitor workforce capacity, manage associated risks and support the continued delivery of safe care for women, babies and families.

Annexe one: CNST MIS Year 8 Safety Action A Assurance Dashboard

Safety Action A requires organisations to demonstrate safe workforce planning and capacity management across maternity and neonatal services, supported by appropriate escalation, monitoring and Board oversight. This includes funded workforce establishments, consultant presence, neonatal staffing, safe use of temporary staff and operational capacity management.

Requirement	Current Position	Compliant
Birthrate Plus review completed within last three years	BR+ completed March 24 and further review has just been commissioned and expected to commence later this year.	Yes
Fully funded midwifery establishment that aligns with Birth rate plus review	From 1st April 2026 fully funded	Yes
Midwife vacancy rate monitored	Yes active recruitment	Yes
Compliance with RCOG 'Roles and Responsibilities of the Consultant Providing acute care' standard	Audit in progress	TBC
Short-term locum certification	No short term locums engaged	Yes
24/7 duty anaesthetic availability for obstetric services		Yes
Clear plan for a fully funded neonatal nursing establishment that aligns with BAPM	Compliant, trajectory maintained	Yes
Clear plan for a fully funded neonatal medical establishment that aligns with BAPM	Compliant	Yes
Capacity and escalation processes in place	Yes	Yes
Board oversight evidenced	Yes	Yes

CNST MIS Year 8 SAB: Training compliance risk

11th October 2026
Amy Garratt

Overview

Due to the bi-monthly reporting cycle of the Maternity and Neonatal Oversight Group (MNOG), the Group will receive the planned mid-point CNST update which demonstrates that, at the July 2026 checkpoint, the Trust had achieved compliance across all required staff groups and remained on track to meet the November 2026 CNST MIS submission requirements. At that point, although a number of workforce and attendance risks had been identified, the level of booked training, planned training capacity and mitigating actions in place provided reasonable assurance that the Trust would achieve the required 90% compliance standard for the November 2026 submission.

However, since completion of the mid-point review, further training events have taken place, and significant operational challenges have emerged. As a result, the risk profile has changed. Whilst achievement of the training requirements remains technically possible, compliance is now heavily dependent on attendance at the remaining sessions, particularly within the anaesthetic workforce, where escalating staffing pressures and the inability to consistently release staff for training have significantly increased the likelihood of non-compliance.

This risk is particularly significant as failure to achieve the required compliance for this action would result in an overall non-compliant CNST submission. Unlike other CNST actions, there is no provision to submit an action plan or provide implementation evidence following submission to secure a compliant outcome. Consequently, if the required training compliance is not achieved by the submission deadline, the Trust will be required to submit a non-compliant CNST MIS Year 8 return, irrespective of its performance against all other safety actions. This presents a significant financial, regulatory and reputational risk to the Trust.

Current position

Staff group	Number of non-compliant	Number booked	Minimum attendance for compliance	Anticipated compliance 31/11/2026 If ALL bookings come to fruition	Risk to compliance
Obstetric anaesthetists	10	2	7	<90%	Significant: 2/7 booked
On-call anaesthetists	5	0	4	<90%	Significant: 0/4 booked
Neonatal consultants (NLS)	5	0	5	<90%	Significant: 0/5 booked
Neonatal other (NLS)	8	0	8	<90%	Significant 0/8 booked
Obstetrics other (Tier one)	6	2	4	<90%	Moderate: 2/4 booked, bookings anticipated
Support staff	19	13	13	>90%	Moderate: 100% attendance required
Neonatal nurses (NLS)	2	2	2	>90%	Moderate: 100% attendance required
Obstetric consultants/SAS	9	7	5	>90%	Minimal: Overbooked
Midwives	57	48	27	>90%	Minimal: Overbooked
ANNPs (NLS)	0	0	0	>90%	No risk: Fully compliant

Key risk areas:

Anaesthetic compliance: The most significant risk to achievement of CNST MIS Year 8 Safety Action B relates to the anaesthetic workforce. The Clinical Lead for Anaesthetics has advised that the service is operating with critically low staffing levels, compounded by recent organisational change, sickness absence and leave commitments. Current workforce capacity is focused on maintaining emergency and urgent clinical services, with limited ability to release staff for training. Historical arrangements that supported backfill for PROMPT attendance are no longer available, and planned workforce expansion has not yet been approved.

As a result, there is a significant risk that the required training compliance cannot be achieved. Currently, 10 obstetric anaesthetists are expired or due to expire before the 30th November submission deadline, with only 2 booked onto a remaining PROMP day. A minimum of 7 attendances is required to achieve compliance.

The risk has been further compounded by a delay in identifying and escalating a reduction in anaesthetic bookings, resulting in less time available to implement mitigation actions. During this period, the maternity education team was managing increased operational demands, including delivery of training programmes and supporting clinical services during periods of staffing pressure. As a result, opportunities for earlier intervention and escalation were reduced.

The circumstances have been reviewed, and the education team has strengthened monitoring and escalation processes to reduce the likelihood of recurrence. While earlier escalation may have provided additional time to support recovery actions, the current risk remains significantly influenced by workforce availability and staff release for training.

Mitigation and Recovery Actions:

A: The Clinical Lead for Anaesthetics has emailed those members of staff who are expired and due to expire with the next available PROMPT dates and advised them to book onto the courses if they are able.

B: To maximise anaesthetic compliance before the CNST submission deadline, alternative training delivery options are being explored. CNST guidance permits half-day attendance for anaesthetists where all relevant drills are included, although PROMPT has historically been delivered as a full multidisciplinary training day.

Proposed mitigations include:

- Delivery of a bespoke half-day PROMPT session for anaesthetists to reduce the requirement for clinical backfill.
- The session would have both midwifery and obstetric attendance to ensure MDT learning.
- Utilisation of an existing Anaesthetic Governance Day before the November submission deadline to support attendance.
- Consideration of delivering the session twice on the same day (morning and afternoon) to maximise participation.
- Continued engagement with anaesthetic leadership to identify further opportunities to release staff for training.

A draft half-day programme is under development and, subject to agreement with anaesthetic leadership, can be progressed as a targeted recovery action. Whilst these measures cannot fully mitigate the workforce challenges affecting the service, they represent the most realistic opportunity to improve compliance ahead of the final CNST submission.

Neonatal medical staff: Multiple Neonatal Life Support (NLS) update drop-in sessions have been offered to medical colleagues throughout the reporting period; however, uptake and attendance have remained below the level required to achieve compliance. As a result, a significant risk has emerged due to the number of staff still requiring training before the CNST submission deadline. This risk has been regularly escalated and discussed with neonatal leadership teams.

A recovery plan is now in place, including targeted delivery of NLS updates during existing medical working days to maximise attendance opportunities. Whilst compliance is currently anticipated to be achievable, this will require significant additional effort from both the neonatal and maternity education teams, including the provision of extra training sessions and targeted support to ensure all remaining staff receive the required update before the submission deadline.

Tier one obstetricians: Outstanding training requirements within the Tier 1 obstetric workforce have been escalated to and are being actively managed by the Obstetric Service Managers. Targeted engagement with individual staff members is underway to secure attendance at the

remaining training sessions. Based on current booking trajectories and the actions in place, it is anticipated that the required compliance threshold will be achieved by the submission deadline.

Support staff: Supporting staff bookings have now reached the minimum level required for compliance; however, achievement remains dependent upon all booked individuals attending. Additional bookings are being actively pursued to strengthen resilience against unavoidable non-attendance.

Neonatal nurses: Neonatal nurse bookings have now reached the minimum level required for compliance; however, achievement remains dependent upon all booked individuals attending

Recommendations

Members of the MNOG, GQC and Trust Board are asked to endorse the following recommendations to support delivery of CNST MIS Year 8:

1. Approve the development and delivery of a bespoke PROMPT training session for anaesthetic staff, utilising the existing Anaesthetic Governance Day scheduled prior to the November 2026 CNST submission deadline, as a targeted mitigation to maximise training compliance.
2. Seek assurance from Divisional and Anaesthetic Leadership regarding the actions being taken to release the remaining anaesthetic staff required to attend training and achieve the minimum compliance threshold for CNST submission.
3. Support continued executive oversight of the risk through existing governance arrangements, recognising that failure to achieve the required training compliance will result in an overall non-compliant CNST MIS Year 8 return, irrespective of performance against all other safety actions.

United Lincolnshire Teaching Hospitals NHS Trust



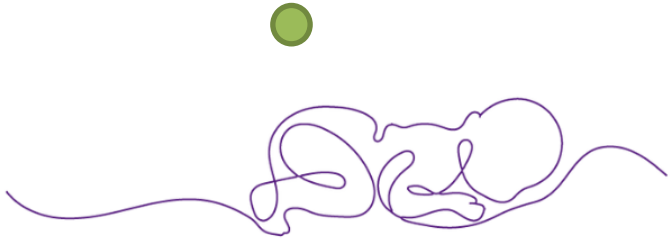
Learning and Actions Thematic Report

Q1 2026/27

Gemma Rayner
Risk and Governance Midwife

August 2026

Caring and building a healthier future for all



Contents

Contents 2
Executive Summary 3
Background 3
Sources of Learning and Safety Intelligence 4
Key Themes and Learning Identified 5
Learning Prioritised for Improvement 8
Actions, impact and effectiveness 9
Outstanding Actions ....**Error! Bookmark not defined.**
Emerging risks and trends 10
Board Assurance and Executive Support Required 10
Appendices: 11

Executive Summary

iNeed *Making escalation easier*	
To ALERT *What we need you to know*	• Trust stillbirth rate is above the national average over the past 12 months therefore an independent thematic review of all stillbirths from June ’25 – May ’26 being undertaken by the Corporate Governance team. All ongoing and new cases that meet the MBRRACE criteria are reported within the 7 days and follow the PMRT process remaining compliant with CNST safety action C.
To ADVISE *What we are already doing*	• Monitoring the homebirth suspension rate through QR code to improve compliance and accuracy of the data (maternity and neonatal 10-point plan)
To ASK *What we need from you*	• Trust support with the implementation of national MEWS within all inpatient settings outside of maternity. • Bereavement Facilities at the Lincoln site – currently going through the approval processes.
To ASSURE *What is on track*	• Full compliance with CNST safety action C

Background

In line with CNST Maternity Incentive Scheme Year 8, Safety Action C, providers are required to produce regular thematic reports demonstrating learning from maternity and neonatal incidents, investigations, complaints, claims, reviews and other sources of safety intelligence, and to evidence how this learning is translated into measurable improvement. This report forms part of the Trust’s commitment to creating a culture of

openness, continuous learning and improvement, ensuring that lessons identified are systematically analysed, shared and embedded across maternity and neonatal services.

The report provides a thematic review of key learning identified through local and external reviews, patient safety incidents, complaints, coronial investigations, PMRT reviews, MNSI criteria cases and wider safety intelligence. It aims to identify recurring themes, highlight areas of good practice, monitor progress against improvement actions and provide assurance that learning is informing changes in practice, reducing risk and supporting the delivery of safe, effective and compassionate care for women, babies and families.

Progress at United Lincolnshire Teaching Hospitals Trust (ULTH) is overseen through the bi-monthly MNOG. In line with NHSE requirements, outputs from MNOG are escalated to the Group Quality Committee (GQC), a sub-Board committee with delegated authority for maternity and neonatal safety. This governance structure ensures robust scrutiny of data, themes, risks and learning, providing the Trust Board with clear, timely insight into quality and safety performance, including areas requiring urgent focus. MNOG is chaired by the Director of Nursing, who is also the Executive Maternity Safety Champion, and attended by the Non-Executive Maternity Safety Champion.

Actions arising from incidents, investigations, reviews and safety intelligence are recorded and tracked through Datix in line with established Trust processes. Where actions have wider strategic, regulatory or have wider safety significance, they are also incorporated within the single, integrated Perinatal Safety Improvement Plan (PeriSIP), providing consolidated oversight of perinatal safety improvement activity and associated assurance. The PeriSIP is maintained as a live document, with new actions added as they are identified. Following the bi-monthly PeriSIP-focused discussion at the Perinatal Safety Collaborative meeting, in which actions are reviewed, progress is challenged, and learning is shared, a headline report is generated and shared at MNOG as an appendix within the Perinatal Assurance Report. Actions are archived once MNOG has received assurance that changes in practice have been embedded and that appropriate ongoing monitoring arrangements are in place. Oversight and assurance are further supported through regular internal reporting to maternity, neonatal and perinatal governance forums, with external reporting to system-level quality and safety meetings, including the LMNS and ICB, ensuring robust governance, transparency and sustained focus on perinatal safety improvement.

Sources of Learning and Safety Intelligence

Where has the learning come from?

Maternity and neonatal services utilise a wide range of local, regional and national sources of safety intelligence to identify opportunities for learning, drive quality improvement and provide assurance regarding the safety and quality of care. Learning is triangulated from incidents,

investigations, reviews, audits, performance metrics, patient and staff feedback, regulatory inspections, national programmes and external assurance processes to ensure that emerging themes, risks and examples of good practice are identified promptly and acted upon

This section summarises the key sources of learning reviewed through established governance arrangements, including patient safety incidents and investigations, PMRT reviews, MNSI and EN cases, complaints and feedback, staff experience, performance against national programmes such as the Saving Babies' Lives Care Bundle, MOSS, the Three Year Delivery Plan and Maternal Care Bundle, alongside intelligence from external organisations including the CQC, NHS England, Operational Delivery Networks and national reviews. Collectively, these sources provide a comprehensive picture of service performance and inform the identification, prioritisation, implementation and evaluation of improvement actions across maternity and neonatal services.

Key Themes and Learning Identified

What are we learning?

Review of the available safety intelligence demonstrates a number of consistent themes across maternity and neonatal services.

Key themes/learning	Detail	Source
Workforce, Capacity and Sustainability	Homebirth service partial and full suspensions are being monitored through a new QR code (launched 20/4/26) to attempt to increase compliance and to provide more detail as to the reason for the suspension. Total suspensions for Q1 – 41.	Datix, Teams Forms
Communication, Escalation and Multidisciplinary Working	There have been 3 MNSI reports published in Q1: - MI-047284 – 0 recommendations, 4 prompts - MI-049360 – 0 recommendations, 0 prompts - MI-049361 – 2 recommendations, 2 prompts o Ensure use of emergency buzzer in an emergency o Strengthen approaches to promote civility	MNSI (Three Year Delivery Plan)

Early Recognition, Risk Assessment and Clinical Decision-Making	• Referrals delayed (top cause of claims by volume) – There is a theme emerging where following booking appointments the referrals are not being sent through via the maternity digital system – Community Matron to undertake a review to establish themes and actions to rectify the issue.	Claims, Datix (Claims Scorecard)
	• Leading reason for submission of daitx's in Q1 was term baby admitted to neonatal unit (85). All admissions are reviewed thematically through the ATAIN process.	Datix
	• Incident investigations - theme of delayed recognition of a deteriorating patient. Comparisons of the current MEWS and the national maternity early warning score (NMEWS) have been undertaken to support the launch across the trust. It has recognised that escalation would have been recommended earlier in the deterioration.	Incident Investigations, Maternity Care Bundle
Listening to families: patient experience	Patient feedback from PMRT reviews: • Lack of Consultant Review - Throughout my pregnancy, I did not have any appointments with my named consultant. • The sibling pack provided for our older daughter was thoughtful and supportive. • Staff helped us create mementos with our daughter after her birth, which we will always treasure.	PMRT

	• Staff were very accommodating, allowing us to spend time with our baby, handle her gently, and create memories. • I feel upset that a review has to take place as no one is to blame for this. I want everyone to know that the care I received was exemplary, everyone was amazing. Even the little things were thought of, such as sugar in my urine and another GTT was carried out. Even the small things were thought of.	
Estates, facilities and infrastructure	**Only Lincoln Cases** - Mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the necessary facilities are not available.	PMRT
Reduction in Stillbirth and Perinatal Mortality	Lincoln's stillbirth rate is currently at 5.11 per 1000 which remains above the national trajectory (≥3.8 per 1000), Between June 2025 and June 2026, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) recorded 23 stillbirths across maternity services, with the majority occurring at Lincoln County Hospital. Cases occurred across a range of gestations, including a number of late gestation and term stillbirths. Early review has not identified any obvious systemic failures; however, a number of cases remain under review through the Perinatal Mortality Review Tool (PMRT) process and initial findings suggest several recurring themes warrant further exploration, including reduced fetal movements (RFM), late presentation, fetal growth concerns, and complex clinical risk factors.	MBRRACE

	This is currently monitored through the PeriSIP action plan and is on the trust risk register as high risk.	

Learning Prioritised for Improvement

What learning has been prioritised and why?

Number	Key themes/learning	Prioritisation rationale
1	**Reduction in Stillbirth and Perinatal Mortality**	Following the recent increase in stillbirths at Lincoln County Hospital over the past 12 months the region has advised we undertake a focused programme of assurance and improvement work over the next 6 months to better understand whether there are any recurring themes, identify potentially modifiable factors and strengthen our preventative actions. The region suggests key areas of work need to be: • Review of the four 38-Week Stillbirths from the past 12 months • Review of Pre-Term Stillbirths from past 12 months • Ethnicity and Health Inequalities Review • Reduced Fetal Movements (RFM) Quality Improvement Work • PMRT Timeliness and Learning - support timely organisational learning. • Enhanced Surveillance – next 6 months to establish enhanced monthly surveillance of stillbirths through existing governance arrangements. An independent thematic review has been commissioned through the corporate governance team to identify any contributory factors and provide additional assurance.
2	**Listening to families: patient experience**	• Recent national recommendations, including the Amos Review, have reinforced the importance of listening to women and families as a key component of safe and effective care:

		• Lack of Consultant Review – “Throughout my pregnancy, I did not have any appointments with my named consultant.” This has been brought up through several PMRT reviews, the expectations of the patients and families as to what consultant lead care involves is not being explained and therefore leading to a feeling their care doesn’t align with the recommended standards of practice.
3	**Communication, Escalation and Multidisciplinary Working**	• Reinforce staff understanding that the emergency buzzer is not solely a mechanism for obtaining additional people in the room, but a critical safety intervention that mobilises the wider maternity team and supports a coordinated response to obstetric emergencies. • Review and enhance multidisciplinary obstetric emergency training and simulation using human factors principles to strengthen communication, psychological safety and team coordination during periods of high cognitive workload and rapidly evolving clinical situations.
4	**Early Recognition, Risk Assessment and Clinical Decision-Making**	As part of the maternity care bundle implementation plan the launch for national MEWS across all inpatient settings is due with the launch of Nerve Centre. All staff need to have undertaken the e-learning prior to launch, comms being launched to support.
5	**Estates, facilities and infrastructure**	Bereavement Suite development on the Lincon site is the key theme from PMRT, there is currently in-equality between the sites, and we are not complainant with the national bereavement care pathways.

Actions, impact and effectiveness

What actions have been undertaken in response to identified learning?

Number	Key themes/learning	Actions	Impact/effectiveness assessment
1	**Reduction in Stillbirth and Perinatal Mortality**	An independent thematic review has been commissioned through the corporate governance	To be completed - end October 2026 TOR – Appendix 1.6

		team to identify any contributory factors and provide additional assurance.	
2	**Listening to families: patient experience**	Leaflet to be developed to be available to push for all consultant led care patients on badger notes.	To be completed - November 2026
3	**Early Recognition, Risk Assessment and Clinical Decision-Making**	National MEWS to be launched alongside nerve centre in October '26	To be completed – October 2026
4	**Estates, facilities and infrastructure**	Bereavement Facilities – Ongoing planning for the transformation to a labour wardroom with soundproofing.	Being monitored through the PeriSIP action plan

Emerging risks and trends

What new concerns or trends have been identified?

Risk/trend	How will these be monitored?	Additional actions if required
Full and partial suspension of the Homebirth service	Submission of the QR code	Discussion around the addition to the risk register – Following the maternity and neonatal 10 point plan
Following booking appointments, the referrals are not being sent through via the maternity digital system	Datix	Implementation of digital 'drop in' sessions for community staff and exploration of return to face-to-face booking appointments

Board Assurance and Executive Support Required

What do we need from the Executive Board?

- Trust support with the implementation of national MEWS within all inpatient settings.
- Bereavement Facilities at the Lincoln site – currently going through the approval processes.

Appendices:

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

Appendix number	Title
1.1	Appendix 1.1 - LMNS QS report April 2026
1.2	Appendix 1.2 - LMNS QS report May 2026
1.3	Appendix 1.3 - LMNS QS report June 2026
1.4	Appendix 1.4 – PMRT Q1 report – non-identifiable data
1.5	Appendix 1.5 - Claims Scorecard Q1 '26-'27
1.6	Appendix 1.6 – Stillbirth assurance terms of reference

PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT (QUARTER 1 – April – May '26)

1. INTRODUCTION

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

1.1 DEFINITIONS

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

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

2. STANDARDS

CNST MIS Year 8 represents a shift from the prescriptive, process-driven requirements of Year 7 to a more streamlined, outcomes-focused approach to learning from perinatal deaths. In Year 7, PMRT was a standalone safety action with defined compliance metrics, including strict timelines, percentage thresholds for reviews, and mandated elements such as parental involvement and external panel attendance. In contrast, Year 8 incorporates PMRT within a broader "learning from reviews and investigations" framework, placing less emphasis on meeting specific numerical targets and more on demonstrating the quality of learning, meaningful family engagement, and how insights from reviews

lead to measurable improvements in care. This change reflects a wider move towards board-level accountability, triangulation of learning across multiple sources, and evidencing real impact on safety and outcomes rather than solely evidencing completion of processes

CNST MIS Year 7 vs Year 8 – PMRT Requirements

Area	Year 7 (MIS)	Year 8 (MIS)
Structure of Requirement	PMRT is a standalone Safety Action (SA1) with specific requirements	PMRT is incorporated into a broader Safety Action on learning from reviews and investigations
Overall Approach	Process-driven with prescriptive standards and measurable compliance thresholds	Outcomes-focused, principles-based approach emphasising impact and improvement
Compliance Metrics	Defined targets (e.g. % of reviews completed, parental engagement rates, external reviewer involvement)	Reduced emphasis on fixed numerical targets; focus on quality and effectiveness of learning
Timeliness	Strict timelines for starting and completing reviews (e.g. within 2–6 months)	Timeliness still expected but assessed in terms of meaningful and timely learning rather than strict deadlines alone
Family Engagement	Required to evidence parental involvement in a set percentage of cases	Broader focus on meaningful service-user engagement and experience
Focus of PMRT	Demonstrating that reviews are completed to the required standard	Demonstrating how learning from reviews leads to changes in practice and improved care
Governance Requirements	Regular (e.g. quarterly) PMRT reporting to the Trust Board for assurance of compliance	Increased emphasis on Board-level accountability for learning, triangulation, and safety culture
Evidence & Assurance	Detailed evidence submission against each requirement	Evidence primarily held locally with Board assurance and declaration of impact
Key Theme	Compliance with PMRT process	Demonstrable learning, improvement, and impact on outcomes

CNST year 8

The MIS Year 8 scheme was released in May 2026 and will apply to babies who have died between 1st December 2025 until 30th November 2026.

From Q1 onwards, the Trust will transition to align with the CNST MIS Year 8 requirements. This represents a shift to a more integrated and intelligence-led approach to safety learning across maternity and neonatal services. As part of this, the existing PMRT reporting will be incorporated into a single, consolidated thematic reporting framework. This framework will triangulate learning from multiple sources, including MNSI and NHSR Early Notification reports, PSIRF reviews, PMRT outputs, MOSS safety checks, NHSR claims scorecards, and relevant national guidance. Thematic reports will focus on identifying recurrent themes, tracking progress against actions, and evidencing how learning is embedded into practice, including through multidisciplinary training. There will also be a strengthened focus on the use of demographic data to identify and address any

disparities in outcomes. These reports will be reviewed collaboratively with the Perinatal and Board-level Safety Champions and presented to the Trust Executive Board on a quarterly basis, providing enhanced oversight, assurance, and visibility of safety improvement and compliance with CNST requirements.

Standard C Learning from reviews and investigations			% targets
Reporting and Reviewing	1. Notify all qualifying events	**All** eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI **as soon as possible** after the death/diagnosis.	**No%** **7 working days (Locally agreed process)**
	2. Seek parents' views of care	For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.	**No %**
	3. External multidisciplinary reviewers	For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.	**60%** **(CNST requirement)**
Sharing information with families	4. Provide relevant information	Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candor must be provided for all parents where the event is eligible for duty of candor.	**No %**
	5. Offer parents a meeting with relevant specialists	Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	**No %**

Learning and Governance	6. Thematic reports of learning and actions	The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.	**Minimum of quarterly**

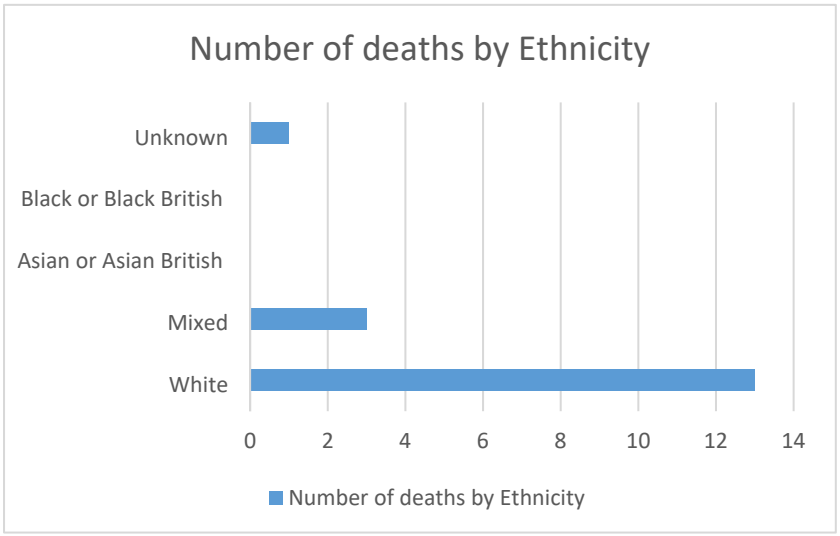
3 RECOMMENDATIONS

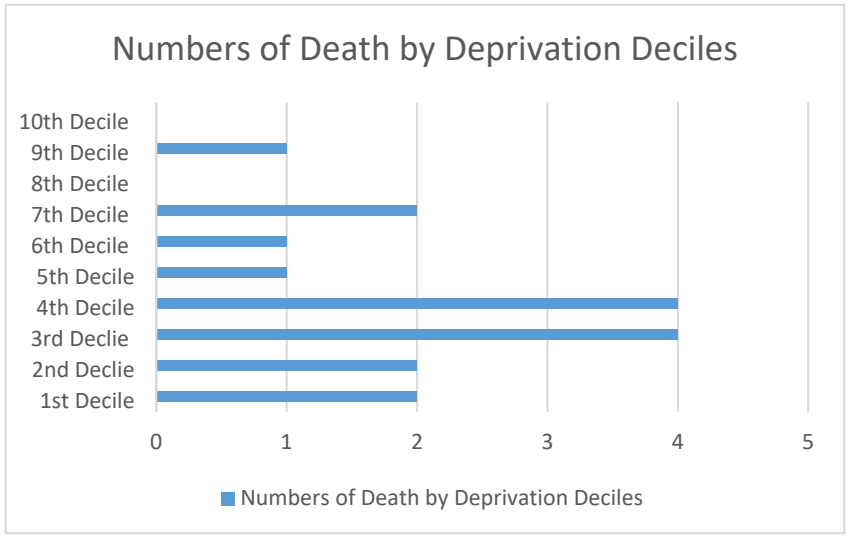
3.1 Eligible Incidents in 2025-2026 - CNST year 8

There have currently been 17 cases reported within the next CNST timeframe. Of these, 12 are internal cases where the babies were born and died within the Trust, and 5 are external cases where care was provided by the Trust during the antenatal, intrapartum, or postnatal period, but the babies died elsewhere.
All of the cases are still going through the PMRT process following the year 8 standards.

3.2 Maternal ethnicity and Deprivation Data CNST year 8

Current ethnicity data for CNST year 8 indicates that 13 of the 17 cases are white British and the majority of the cases are from the lower deprivation deciles, with 13 cases living in the 5th decile and below.





3.3 Summary of all incidents closed in Quarter 1

There have been 10 reports published in Q1, 6 from the Year 7 CNST reporting period and 4 from the current CNST reporting period (Year 8). This is broken down into the care provided to the mother before the death of the baby, the care of the mother after the death of the baby. The care of the baby from birth until death is reviewed for any neonatal death cases. (Full reports are available for review – Appendix 1-10)

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

- 8 - Care issues which they considered would have made **no difference** to the outcome for the baby
- 2 - Care issues which they considered **may have made a difference** to the outcome for the baby

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

- 1 – No care issues identified
- 4 - Care issues which they considered would have made **no difference** to the outcome for the mother
- 1 – Care issues which they considered **may have made a difference** to the outcome for the mother

Grading of the care of the baby from birth up to the death of the baby (NND cases only)

- 1 - Care issues which they considered would have made **no difference** to the outcome for the mother
- 1 – Care issues which they considered **may have made a difference** to the outcome for the mother
- 1 – Care issues which they considered were **likely to have made a difference** to the outcome for the baby (Case is now neonatal PSII)

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

3.4 CNST Compliance as per MIS Year 8 Standards (Table 1)

For CNST Year 8 standard C covers not only PMRT

CNST year 8 standard C			Q4	Q1	Q2	Q3	Total
Reporting and Reviewing	1. Notify all qualifying events	**7 working days (locally agreed)**	**6/6**	**8/8**			**14/14**
	2. Seek parents' views of care	**No%**	**100%**	**TBA**			**N/A**
	3. External multidisciplinary reviewers	**60% (CNST requirement)**	**60%**	**TBA**			**N/A**

Sharing information with families	4. Provide relevant information	**No%**	**6/6**	**8/8**			**6/6**
	5. Offer parents a meeting with relevant specialists	**No%**	**TBA**	**TBA**			**N/A**
Learning and Governance	6. Thematic reports of learning and actions	**Minimum Quarterly (CNST requirement)**	**Yes**	**Yes**			**2/2**

3.5 Learning and Action Logs for Outstanding Cases

The actions for all published PMRT cases are added to Datix IQ Mortality Module and a live register is produced for this report of all remaining open actions. Any actions closed within the reported quarter will therefore be deleted from the previous quarter's action log. There are currently 11 overdue actions and these are reviewed thought the monthly action meeting.

4.0 Saving Babies Lives Version 3.2

SBLCBv3 provides evidence-based best practice for providers and commissioners of maternity care across England, to reduce perinatal mortality. There is an expectation that as well as organisations reporting on their implementation of each element, there will be complimentary reporting of ongoing improvement work (with associated detail of interventions and improvement in process measures and outcomes) for each element. An integral component of this improvement work will be a focus on learning from incidents or enquiry. Harm may have occurred in relation to implementation of or non-compliance with an element of the SBLCB. The use of the Perinatal Mortality Review Tool will complement the investigation and learning in this context. Of the 10 cases reviewed there 0ne action created in relation to SBL CBv3 element 6 due the management of a patient with existing diabetes.

5.0 Escalation

5.1. Following the recent increase in stillbirths at Lincoln County Hospital over the past 12 months the region has advised we undertake a focused programme of assurance and improvement work over the next 6 months to better understand whether there are any recurring themes, identify potentially modifiable factors and strengthen our preventative actions. The region suggests key areas of work need to be:

- Review of the four 38-Week Stillbirths from the past 12 months
- Review of Pre-Term Stillbirths from past 12 months
- Ethnicity and Health Inequalities Review
- Reduced Fetal Movements (RFM) Quality Improvement Work
- PMRT Timeliness and Learning - support timely organisational learning.
- Enhanced Surveillance – next 6 months to establish enhanced monthly surveillance of stillbirths through existing governance arrangements.

This work will be monitored through the existing governance processes and will be done alongside the existing PMRT workstream. The current cases being reviewed are from April 2026 and there are currently 5 internal cases and 2 external cases to be reviewed.

5.2. MBRRACE have published 'Perinatal Mortality Review Tool Best Practice Standards for conducting PMRT reviews', we will be benchmarking against the document, and any outstanding actions will be added to the PeriSIP and highlighted in PMRT Q2 report.

Author – Gemma Rayner, Risk and Clinical Governance Midwife

Date – 6th of July 2026

Maternity Incentive Scheme, year 8 - Safety Action - C
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

United Lincolnshire Hospitals NHS Trust

Claims Scorecard - April '15 – March '25

Top injuries by volume:	Top injuries by value:
• Unnecessary pain (15) • Stillborn (13) • Psychiatric/psychological damage (10) • Fatality (5) • Brain Damage(4)	• Brain damage (4) • Psychiatric/psychological damage (10) • Stillborn (13) • Unnecessary Pain (15) • Fistula (1)
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (25) • Intra-op Problems (6) • Fail to warn – informed consent (5) • Fail to respond to abnormal FHR (5) • Failure/delay in diagnosis (5)	• Fail to respond to abnormal FHR (4) • Inadequate nursing care (4) • Failure to monitor 2nd stage (1) • Medication Errors (2) • Intra Op problems (6)

Complaints Q1 '26 – '27

There have been 10 complaints received:
4 – Clinical treatment
3 – Communication
3 – Values and Behaviours

Incidents Q1 '26 -'27

397 datix's were submitted during Q1:
1. Term Baby admitted to neonatal unit (ATAIN) – 85
2. Readmission of Mother – 29
3. PPH >1500mls – 27
4. Referral delayed – 24
5. 3rd/4th degree tears - 17

Harm levels:
No Harm – 317, Low Harm – 75, Moderate – 5

2 referral to MNSI both intra-partum stillbirths

Themes Q1 '26 -'27

- **Incidents** - There has been an increase in the stillbirth rate for the trust, discussed with the region for advice and targeted work to review stillbirths for the past 12 months to be undertaken.
- **Incidents / Claims** - Referrals delayed (top cause of claims by volume) – There is a theme emerging where following booking appointments the referrals are not being sent through via the maternity digital system – Community Matron to undertake a review to establish themes and actions to rectify the issue.
- **Incidents** – Rise in 3rd/4th degree tears, the establishment of the Perineal Health Service reviews every case and ensures comprehensive follow up for each patient

Learning Q1 '26 -'27

- 2 MNSI final reports received:
  - 1 – no safety recommendations or prompts
  - 1 – 2 recommendations (Ensure use of emergency buzzer in an emergency, strengthen approaches to promote civility.) and 2 prompts (what are barriers for senior clinical oversight at critical stages of care and during VE's fetal positions were not documented)

Action Plan Q1

Not started | In progress | Completed

National MEWS launch through NerveCentre Education program to be launched – **PeriSIP action**	31/10/26
Review of stillbirths in the past 12 months in line with regional advice – monitored through monthly governance updates.	31/12/26
Implementation of digital 'drop in' sessions for community staff and exploration of return to face-to-face booking appointments	30/09/26

Maternal Care Bundle (MCB)

Purpose of the Maternal Care Bundle implementation tool

The Maternal Care Bundle (MCB) was published on 6 January 2026. This optional implementation tool has been developed as a helpful tool to support trusts with a practical and standardised approach to planning, measuring and demonstrating implementation of the MCB. It has been designed to standardise and simplify local planning monitoring and reporting; reduce duplication and variation; and provide trusts with a practical approach to evidencing implementation and quality improvement to trust boards.

Implementing the Maternal Care Bundle

The MCB sets best practice standards across 5 areas of clinical care, for implementation by NHS providers and commissioners across England. The aim is to reduce maternal mortality and morbidity and reduce inequalities in these adverse outcomes.

Organisational roles and responsibilities

As set out in the MCB:

• **NHS trusts providing maternity services** are primarily responsible for implementing the MCB locally, including:
◦ benchmarking current compliance and developing an improvement plan with trajectories for sign off by the trust board
◦ providing regular reports to the trust board on implementation against this plan and trajectories, so that the board can oversee, support and challenge local delivery. Trust boards should also ensure the involvement of all relevant services in the planning and delivery of interventions. This will include relevant medical and surgical specialties, gynaecology and urgent and emergency care, as appropriate
◦ ensuring that where local plans do not meet nationally recommended pathways, timescales or performance, or where local delivery subsequently deviates from these plans, this is escalated to the regional NHS England team
◦ engaging with maternal medicine networks. This means co-producing and complying with the local network's protocol for the management and referral of medical problems in pregnancy, across all relevant medical specialties and settings
◦ local reporting of routine care data relating to key process and outcome measures for each element as defined in the national implementation tool (see below)

• **ICBs** are responsible for ensuring the engagement of wider services within their footprint. This includes the strategic commissioning of relevant services to support delivery of MCB interventions, in line with the Model ICB Blueprint. It also includes facilitating engagement with services on a footprint greater than a single provider trust, for example:
◦ co-ordination with regional ambulance services and primary care
◦ joint working between non-specialised and specialised services (such as maternity and adult neurology services)
◦ escalation of issues between maternal medicine networks and provider organisations

• **regional NHS England teams** are responsible for providing strategic leadership and oversight of performance, in line with the Model Region Blueprint. Therefore, where local plans do not meet nationally recommended pathways, timescales or performance, or where local delivery subsequently deviates from these plans, this should be escalated to the regional maternity team in the first instance, with input from other regional clinical leadership as required

• **maternal medicine networks (MMNs)** are responsible for providing regional leadership and support on the management of medical conditions in and around pregnancy, in line with the national service specification for maternal medicine networks. This includes:
◦ leading the co-production and maintenance of protocols for the management and escalation of medical problems in pregnancy with constituent NHS trusts
◦ providing advice and training relating to these protocols and advice on relevant local pathways as required

Implementation tool Futures platform

The Futures NHS Collaboration Platform includes a variety of resources, videos, testimonials, presentations and freqently asked questions to support the use of the implementation tool. To view the resources or request access to the user guide use the link below:

Maternity and Neonatal Hub - Futures

Contact Us

Queries or questions in relation to the functionality or use of the implementation tool: england.maternitytransformation@nhs.net

Queries or questions in relation to the NHS Resolutions CNST guidance: nhsr.mis@nhs.net

Queries or questions in relation to the Maternal Care Bundle guidance: england.maternitytransformation@nhs.net

Further Support/Information

Maternal Care Bundle - a care bundle for reducing maternal mortality and morbidity

Maternity and Neonatal Hub - Futures

Developed by:

- Charlie Podschies - NHSE
- Charlie Merrick - NHSE
- Alanna Parker - NHSE
- Clinical leads of the MCB (see 'Acknowledgements' in main document)

With thanks to Joanne Hadley and Jenny Brown for their work on the Saving Babies' Lives Care Bundle implementation tool on which this tool is based.

Maternal Care Bundle (MCB)

Document version history

Version	Date Issued	Brief Summary of Change
V1	01/06/2026	Version 1 uploaded to FutureNHS site

Maternal Care Bundle (MCB)

Quick start guide

For more detailed guidance, please view the 'How to complete the tool' worksheet.

This implementation tool is optional and is designed to make it easier to plan, evidence and report progress with MCB implementation and quality improvement.

Workbook layout

Each MCB element has 3 worksheets:

1. Measures worksheet - Contains suggested process indicators and measures and, where available, technical guidance related to measuring and collecting evidence.

2. Evidence worksheet – Includes yellow fields for NHS trusts providing maternity services to record their evidence and quarterly performance, and pink fields for Trust Boards to set performance targets where appropriate and assess implementation status of each intervention.

3. Action plan worksheet – Provides NHS trusts providing maternity services with the opportunity to set and monitor SMART (specific, measurable, achievable, relevant and time-bound) actions to progress towards full compliance for each intervention.

The tool also includes a 'board summary - implementation', 'board summary - action plans' and 'progress & board review record' worksheet:

- Information entered into the individual element ‘evidence’ and ‘action plan’ worksheets automatically pulls through to the 'board summary - implementation' worksheet to provide an overview of current progress towards full implementation across all MCB elements.
- The 'board summary - implementation' worksheet can be extracted for board reports, reducing duplication and administrative burden for trusts.
- The 'board summary - action plans' worksheet pulls together all individual element 'action plan' worksheets in one place and provides more detail on any escalations required by MCB intervention.
- The 'progress & board review record' worksheet can be updated after each quarterly review to provide an overview of progress towards full MCB implementation over time.

Quick links

Measures worksheets:	Element 1	Element 2	Element 3	Element 4	Element 5
Evidence worksheets:	Element 1	Element 2	Element 3	Element 4	Element 5

Action plan worksheets:	Element 1	Element 2	Element 3	Element 4	Element 5
Reporting worksheets:	Board summary - implementation				
	Board summary - action plans				
	Progress & board review record				

First use of the implementation tool (establishing a baseline)

1. In each element 'measures' worksheet, NHS trusts providing maternity services can review the process indicators and measures that can be used to demonstrate progress towards full implementation of the MCB.

2. In each element 'evidence' worksheet, NHS trusts providing maternity services can complete the yellow fields to baseline their current practice against standards of the MCB and self-assess their implementation status against each MCB intervention.

3. In each 'action plan' worksheet, NHS trusts providing maternity services may add SMART actions (specific, measurable, achievable, relevant and time-bound) where interventions are not fully implemented. Escalations required can also be added. If no escalations are required, these cells should be left blank.

4. The Trust Board can use the 'evidence' worksheets to review the evidence and reported performance and complete the pink fields (i.e. set agreed target performance levels from March 2027 where appropriate; and validate service-reported implementation status and provide rationale where required).

The Trust Board's validated implementation status and rationale automatically flow into the element 'action plan' worksheets.

Quarterly review cycle

1. NHS trusts providing maternity services can update the 'evidence' worksheets with latest evidence, performance level and changes to self-assessment.

2. The Trust Board can re-validate the implementation status and, if required, update the rationale.

3. NHS trusts providing maternity services can update their actions and progress in the 'action plan' worksheets.

4. After the Trust Board review, NHS trusts providing maternity services can record the overall percentage of fully implemented interventions in the 'Progress & board review record' worksheet (baseline assessment can be completed after the first review).

Maternal Care Bundle (MCB)

How this tool can support implementation of the Maternal Care Bundle

This optional implementation tool is designed to support maternity services with a clear, standardised and proportionate approach to local planning, measurement and oversight of Maternal Care Bundle (MCB) compliance. This tool is intended to support trusts to baseline current practice against the standards of the MCB; agree trajectories and action plans; and track progress locally towards full implementation. This tool removes the need for individual trusts to develop their own documentation, plans and reporting templates, reducing duplication and administrative burden.

How this tool can support compliance with the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme

As part of Year 8 of NHS Resolution's Maternity Incentive Scheme (CNST MIS), Safety Action E requires that:

"In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.”

The implementation tool is not a requirement for MIS Year 8, but it has been developed to help trusts agree a local plan for the delivery of the Maternal Care Bundle with their Trust Boards. Progress against these plans can be reviewed consistently using the quarterly performance fields, supporting oversight and assurance towards full implementation by March 2027.

How to use the implementation tool - guidance for NHS trusts providing maternity services

Measures worksheets

The element measures worksheets include, where available, technical guidance related to measuring and collecting evidence within the Maternity Services Data Set (MSDS) or another data collection tool. The relevant data items for the process indicators and measures should be recorded where possible on the provider’s Maternity Information System and included in the MSDS submissions wherever possible to NHS England in an MSDSv2 Information Standard Notice compatible format (including SNOMED-CT coding).

Currently, the process measures as defined aren't generated in MSDSv2. While the national MCB team will work to include these measures in MSDSv2.5 (timescales TBC), providers should begin work now to implement the measures and constituent data items into local clinical records and measurement practice.

Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator

Expert consensus recommendations

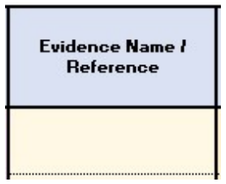
Some of the elements contain expert consensus recommendations and measures. These are not currently interventions within the Maternal Care Bundle, but are recommended for trusts seeking to implement best practice care. Where measures are provided, it is recommended to start recording data against these, to establish a baseline for potential future interventions and improvements to care.

Evidence worksheets

NHS trusts providing maternity services can complete the yellow fields on each of the following evidence worksheets (the pink fields are for completion only by the Trust Board as part of their assurance process):

E1 evidence
E2 evidence
E3 evidence
E4 evidence
E5 evidence

For each intervention within an element, up to four pieces of evidence to be submitted for review and verification by the Trust Board. Each piece of evidence submitted should be named appropriately, and the name should be listed in the 'Evidence Name / Reference' column in the appropriate evidence worksheet. If a piece of evidence relates to multiple interventions, you only need to save and submit the evidence once.



Columns have been provided for services to report quarterly progress against each process indicator and measure, so changes in performance can be monitored.

NHS trusts providing maternity services can self-assess their compliance against the intervention, for the review/agreement of the Trust Board (see below).

Action plan worksheets

Each element has a dedicated action plan worksheet with the opportunity to set and monitor SMART actions (specific, measurable, achievable, relevant and time-bound) to progress towards full compliance for each intervention. NHS trusts providing maternity services can complete the yellow fields on each of the following action plan worksheets.

E1 action plan
E2 action plan
E3 action plan
E4 action plan
E5 action plan

The Trust Board's most recent assessment of progress with implementation in columns P and Q of the 'evidence' worksheet will be automatically pulled through to columns C and D of the relevant element action plan worksheets. These can then inform the actions needed to achieve full compliance.

The actions (column E), progress (column I) and escalations (column J) set out within the individual element action plans are pulled through to the 'Board summary - action plans' worksheet.

Escalations in column J are also flagged in the 'Board summary - implementation' worksheet. If there are no escalations required, column J should be left blank.

How to assure with the tool - Trust Board guidance

Trust Boards should be seeking assurance that all relevant services providing care in the perinatal period are on track to fully implement the MCB by March 2027 and meeting Safety Action E of CNST MIS (Year 8). Trust Boards should review the evidence through their governance frameworks at least quarterly, and validate compliance against each of the standards. This will enable the Trust Board and relevant services to identify common problems and barriers to implementation and develop and share effective solutions.

Overseeing progress with plans and performance against process measures

The interventions of the Maternal Care Bundle are universal, and providers should aim to maximise reliability in local implementation. However, it will be for trust boards to agree locally with provider, what level of performance services should work towards for a given process measure, and the improvement trajectory to meet this.

Once the target performance level for a process measure has been agreed, this can be entered into Column D of the relevant evidence worksheet, against which the provider can then plan and demonstrate progress.

As set out in MIS Year 8, the Trust Board should be assured quarterly that providers are meeting or are on track to meet the required interventions and elements. Where no process measure is provided for a given intervention, it is for the Trust Board to determine locally what is required to demonstrate compliance in clinical practice.

When validating the implementation status of each intervention within each element evidence worksheet; the following criteria can be used:

Element Progress	**Progress Measure**
Fully Implemented	All evidence requirements and, where applicable, the Trust Board required compliance (column D) are met
Partially Implemented	1 or more, but less than all, evidence requirements and, where applicable, the Trust Board required compliance (column D) are met
Not Implemented	None of the evidence requirements and, where applicable, the LMNS required compliance (column D) are met

NHS trusts providing maternity services and their Trust Boards need to meet at the end of each quarter to discuss progress against the MCB. The dates of these meetings can be logged within the tool on the 'Progress & board review record' worksheet.

'Board summary - implementation' and 'Board report - action plans' worksheets

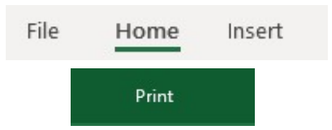
The 'Board summary - implementation' worksheet can be used to generate standardised reports for Trust Boards to oversee, support and appropriately challenge local delivery of the MCB and review any necessary escalations.

Complete the Trust details, date of report and trust accountable officer's name and Trust Board assessors names in the pink fields on the 'Board summary - implementation' worksheet:

Maternal Care Bundle (MCB)

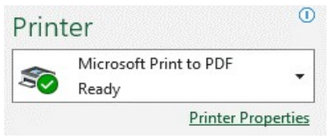
How to create an extract of the implementation tool

The implementation tool can be printed to a PDF by following the instructions below:

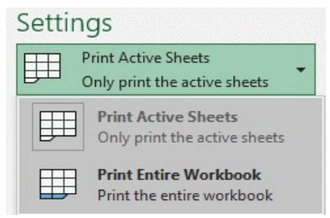


Select File from the Menu Bar or Alt and F (simultaneously) on the keyboard

Select Print from the Menu List or Alt and P (simultaneously) on the keyboard to open the Print Option



Select the Printer option. You can print to a PDF document which can be saved and then emailed or shared.



Change the printer settings to either:
Print only the selected worksheet you are currently viewing; OR

Print all worksheets within the implementation tool.

The page orientation, margins and scaling have been set within the tool and do not need to be changed in the printer settings.



Select Print.

You will be prompted to select the save location and file name for your PDF:



Board report summary: Implementation of the Maternal Care Bundle

Implementation Report

Trust	**United Lincolnshire Hospitals NHS Trust**
Date of Report	**17-Sep-26**
Trust Accountable Officer	**Nerea O'Dongo**
Trust Board Assessor	**Kathyrn Helley**

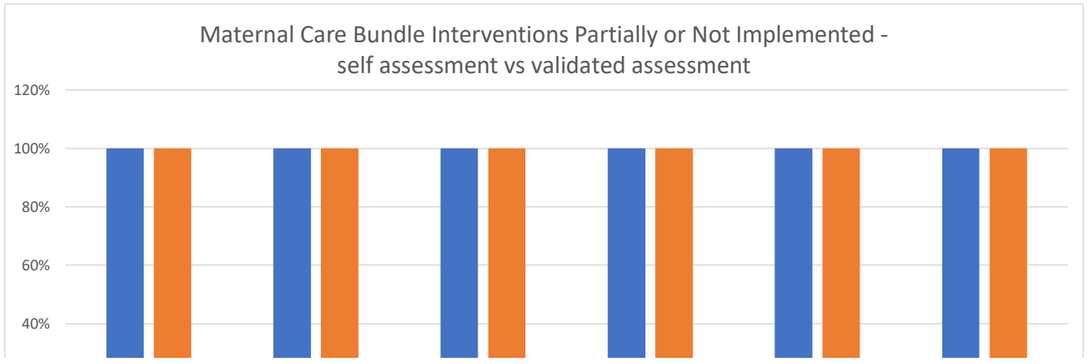
Implementation Grading

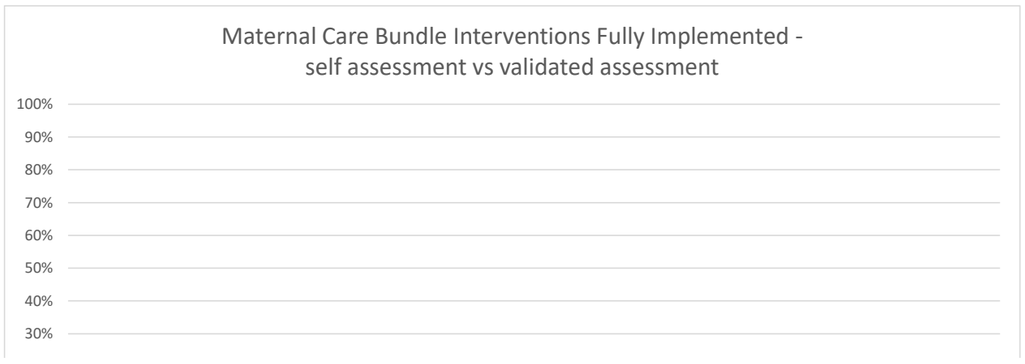
No Assurance - There are fundamental weaknesses in the design and operation of activities and controls such that it is inadequate and likely to fail.

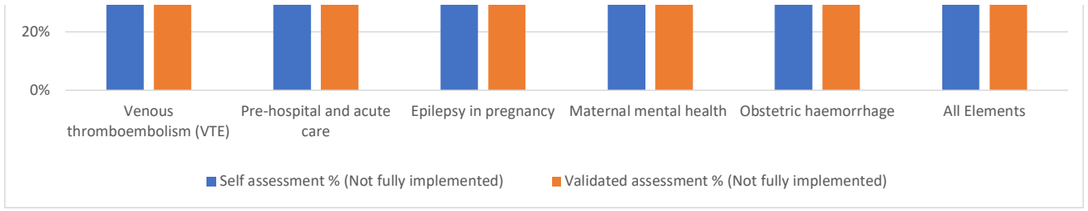
Implementation Progress

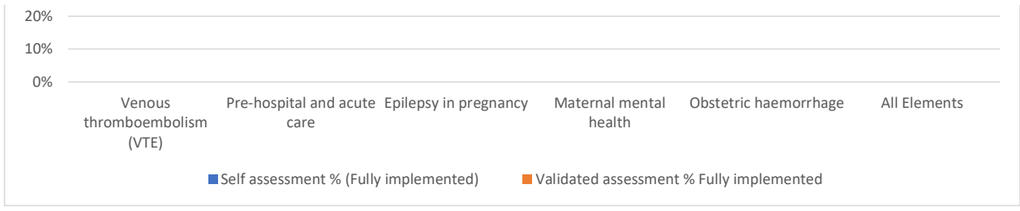
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)	Escalation required for board review*
Element 1	Venous thromboembolism (VTE)	Not implemented	0%	Not implemented	0%	Yes
Element 2	Pre-hospital and acute care	Not implemented	0%	Not implemented	0%	No
Element 3	Epilepsy in pregnancy	Not implemented	0%	Not implemented	0%	Yes
Element 4	Maternal mental health	Not implemented	0%	Not implemented	0%	Yes
Element 5	Obstetric haemorrhage	Not implemented	0%	Not implemented	0%	No
All Elements	TOTAL	Not implemented	0%	Not implemented	0%	

*If yes, please refer to 'Board summary - action plans' worksheet for details.






20%
0%
Venous thromboembolism (VTE)
Pre-hospital and acute care
Epilepsy in pregnancy
Maternal mental health
Obstetric haemorrhage
All Elements
Self assessment % (Not fully implemented)
Validated assessment % (Not fully implemented)


20%
10%
0%
Venous thromboembolism (VTE)
Pre-hospital and acute care
Epilepsy in pregnancy
Maternal mental health
Obstetric haemorrhage
All Elements
Self assessment % (Fully implemented)
Validated assessment % Fully implemented

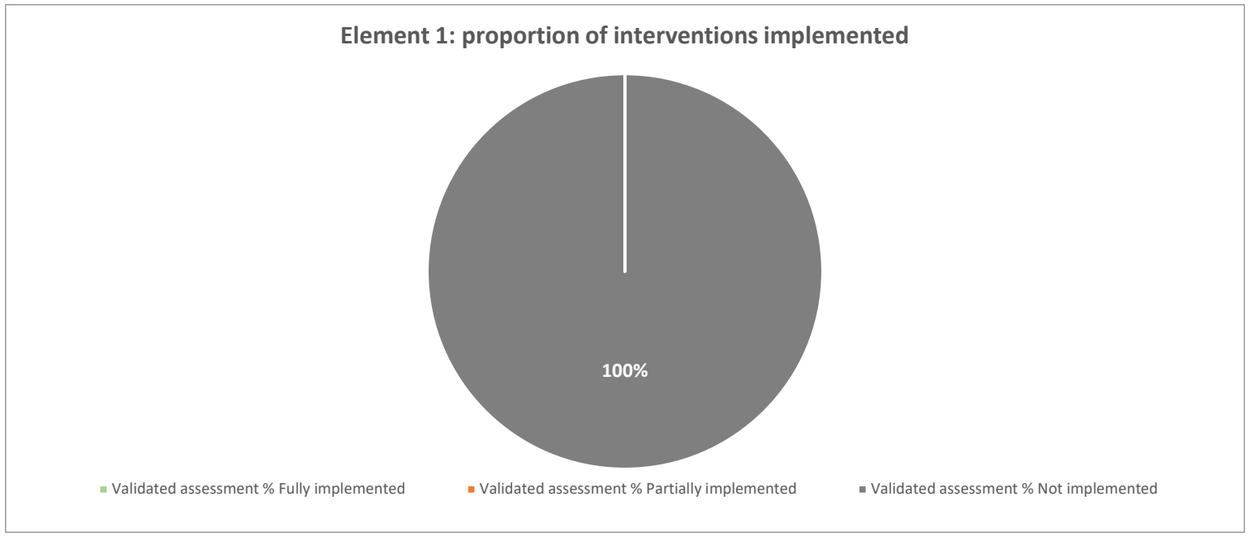
Board report summary: Action plans and escalations for implementation of the Maternal Care Bundle

Action Plan Summary

Element 1

Element 1: Venous thromboembolism (VTE)						
Intervention Ref	**Self-Assessment Status**	**Trust Board Validated Assessment Status**	**Rationale for Trust Board Validated Assessment Status:** If intervention is not deemed fully implemented or partially implemented, why?	**SMART actions to achieve full compliance**	**Progress**	**Escalations required** (If required, specify who and what)
1.1	Not implemented	Not implemented	04/08/2026 - No current pathway for these risk factors - Digital system not currently setup for this process 18-Sept-26: Board Assessor Team Comments: Actions described (on E1 Action Plan) that outline SOP for pathway to identify and act on risk factors and escalation to the Digitial System to enable this. Timescales for SOP to support pathway are 31 March 2027. It would be useful to understand if this could be delivered sooner, as presumably the pathway can be defined whilst waiting on progress with the Digital System.	Escalation to SystmC regarding need for digital specification, also being escalated by East Midlands Maternal Medicine Network by 1st October 2026	For Previous confirmed diagnosis of VTE: We are not submitting 128053003 | Deep venous thrombosis (disorder). This has been escalated to the BI Lead that works with Maternity on 27/7/26 For Hyperemesis gravidarum causing dehydration or immobility: We are not submitting 129598007 | Severe hyperemesis gravidarum (disorder) This has been escalated to the BI Lead that works with Maternity on 27/7/26 For Body mass index (BMI) greater than 50: We are submitting 50373000 | Body height measure (observable entity) and 27113001 | Body weight (observable entity) For all risk factors: The date of this activity is captured as a mandatory data item in MSD201 Care Contact (Pregnancy) We are submitting this to MSDS	Escalation of unreported SNOMED codes to ULTH BI unit and SystmC as required
				Develop draft SOP for maternity pathway for women completing self-assessment via SPA referral by 31st march 2027	18/8/26 In progress	No funding or resource at present to support obstetric prescribing in early pregnancy
				Development of patient resources to support informed decision making by 31st March 2027	18/8/26 In progress	
				Audit to determine expected numbers of women eligible for pathway by 31st march 2027	18/8/26 In progress	
1.2	Not implemented	Not implemented	4/8/26 - This action sits with the ICB. There are no updates currently available from ICB 18-Sept-26: Board Assessor Team Comments: Actions described (on E1 Action Plan) are to await update. Deadline is not aritculated. It would be useful to understand escalation mechanisms and when this is triggered to ensure timescale pace.	Await update from ICB	Informal intelligence received that this action is being reviewed by national team to confirm ownership.	ICB required to complete this action, no updates at present
1.3	Not implemented	Not implemented	18-Sept-26: Board Assessor Team Comments: There is currently limited detail on what actions are required to implement this as part of the	See Intervention 1.1		

1.3	Not implemented	Not implemented	pathway work. Is this a part of the SOP development work planned to be delivered in line with the deadline of 31-March-2027?			

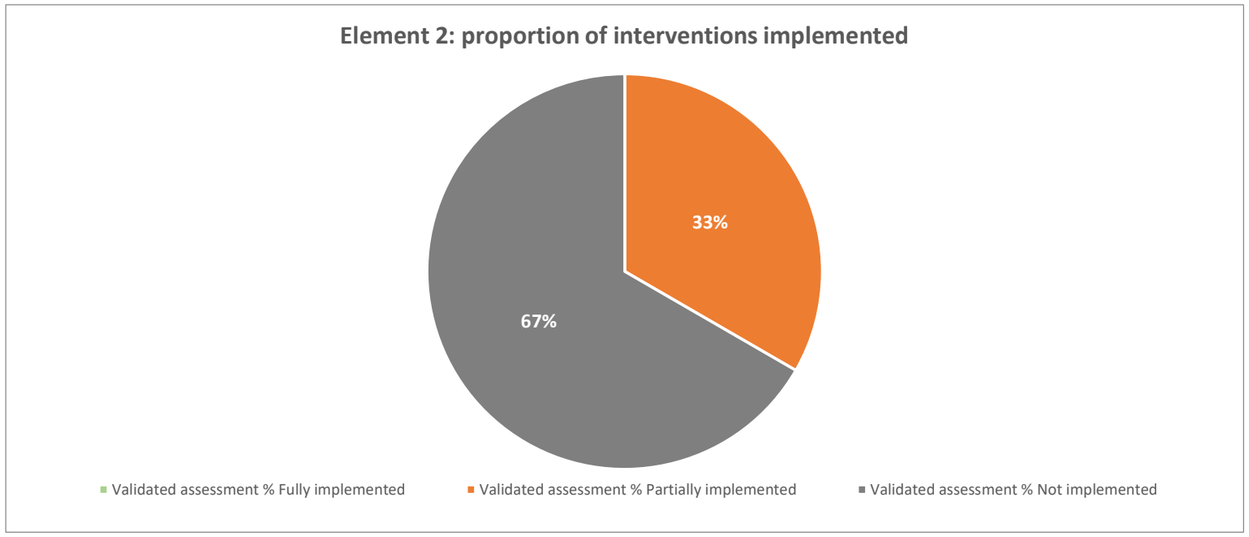


Element 2

Element 2: Pre-hospital and acute care

Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
2.1	Not implemented	Not implemented	04/08/26 2.1a Current electronic observtaions system does not support NMEWS parameters in maternity settings 2.1b Current electronic observations system does not support NMEWS parameters in non-maternity settings 2.1c NMEWS SOP in development in preparation for launch in October 2.1d Unable to audit with current systems, to commence with launch of nervecentre	Develop implementation plan for rollout of NMEWS in maternity settings by 30/09/26	18/8/26 SLT meeting arranged to review implementation plan 1/9/26 Implenmentation plan created and socialised	
				Develop implementation plan for rollout of NMEWS in non-maternity settings by 30/9/26	18/8/26 SLT meeting arranged to review implementation plan 1/9/26 Implenmentation plan created and socialised	
				Develop maternity Deteriorating Patient SOP for use of NMEWS by 01/10/26	18/8/26 Underway	
				Design audit ready for launch of Nervecentre by 30/09/26	18/8/26 Underway	
2.2	Partially implemented	Partially implemented	04/08/26 - Pre-alert system in place with dedicated phone line - SOP required - Signage review completed and works underway to improve, for action plan 23-Sept-26: Board Assessor Team Comments: Dedicated phone line in place with SOP to guide pre-hospital decision making. Its not clear from the SOP as to is this available to EMAS to follow	Develop SOP for ambulance service pre-alert system by 1st October 2026	4/8/26 Underway	
				Develop action plan for signage improvements with estates team including ambulance bays, external signage from local roads, internal signage within buildings by 1st October 2026	4/8/26 Underway and in discussion with estates	

2.3	Partially implemented	Not implemented	04/08/26 - Plan to review current Maternal Medicine Pathway SOP to include acutely unwell women 24-Sept-26: Board Assessor Team Comments: There is a plan to update the current SOP to include this element, with a timescale of the 1 November 2026. At present therefore there is insufficient evidence for anything other than 'not implemented'.	Cons obstetricians to update and review current Maternal Medicine SOP with EMMMN by 1st November 2026	18/8/26 Mat Medicine Consultants emailed with action to review and update guideline with EMMMN	
				Design audit of Maternal Medicine Network referrals including: number and type of referrals, timeliness of response, patient outcomes, equity indicators by 1st	18/8/26 Mat Medicine Consultants emailed with action to design audit	

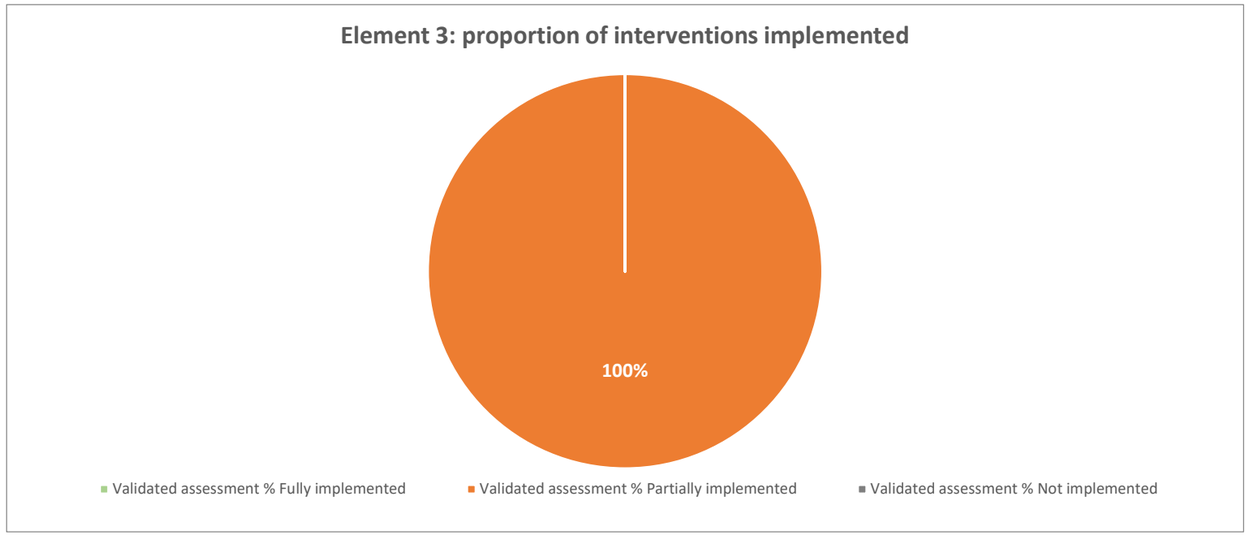


Element 3

Element 3: Epilepsy in pregnancy

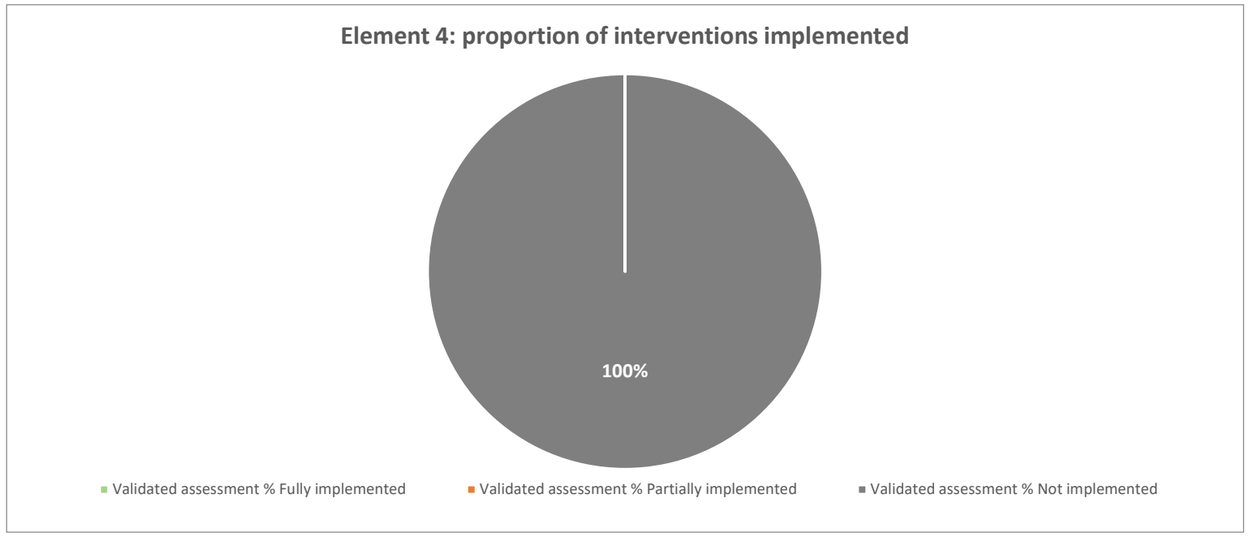
Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Progress	Escalations required (If required, specify who and what)
3.1	Partially implemented	Partially implemented	04/08/26 - Joint clinic established in both antenatal clinics however guidance and processes require review to ensure full compliance with MCB requirements - Obstetric epilepsy support not currently included in epilepsy commissioing 24-September-2026: Board Assessor Team Comments: 'MCB 3.3 Epilepsy Maternity Self Assessment Toolkit v2.0' evidence demonstrates that a local epilepsy in pregnancy team is in place. The	Undertake audit of current practice over last 12 months by 1/11/26	18/8/26 Underway	
				Review evidence of Epilepsy Nurse CPD for management of epilepsy in pregnancy by 1/11/26	18/8/26 To be confirmed	
				Confirm availability of Maternal Medicine Network epilepsy in pregnancy training by 1/11/26	18/8/26 To be confirmed	
				Review commissioning of epilepsy nurses to support joint clinic by 31/3/26	18/8/26 To be confirmed	ULTH Epilepsy service not currently commissioned to provide joint obstetric/epilepsy clinics, requires Trust
			04/08/26 - Largely compliant but need to review current guidance to ensure all required details are	Complete Epilepsy Trust Benchamrking exercise by 14th Sep 26	18/8/26 Underway 10/9/26 Completed and returned to Epilepsy Trust to access Support Offer	

3.2	**Partially implemented**	**Partially implemented**	included in referrals 24-September-2026: Board Assessor Team Comments: 'Management of women with Epilepsy SOP' describes referral criteria to MMM. No evidence of attending training provided.	Review digital specification of badgernet Maternal Medicine Note for documentation of joint neurology documentation and coding of clinics by 31/12/26	Ensure an epilepsy diagnosis is recorded in the following way: We are not submitting 84757009 | Epilepsy (disorder) This has been escalated to the BI Lead that works with Maternity on 22/7/26 Ensure an antenatal epilepsy appointment is recorded in the following way: SNOMED CT Code to record: 185230000 | Seen in neurology clinic (finding) Do not have the option within Badgernet to record Seen in neurology clinic Raised at national MCB meeting MSDS requirement - The date of self-referral is captured in MSD101 Pregnancy and Booking Details. The date of self-referral is not within table MSD101 This has been escalated to the BI Lead that works with Maternity on 22/7/26	Current digital sepcification does not include SNOMED as listed in E3 measures, requires SystemC update



Element 4: Maternal mental health						
Intervention Ref	**Self-Assessment Status**	**Trust Board Validated Assessment Status**	**Rationale for Trust Board Validated Assessment Status:** If intervention is not deemed fully implemented or partially implemented, why?	**SMART actions to achieve full compliance**	**Progress**	**Escalations required** (If required, specify who and what)

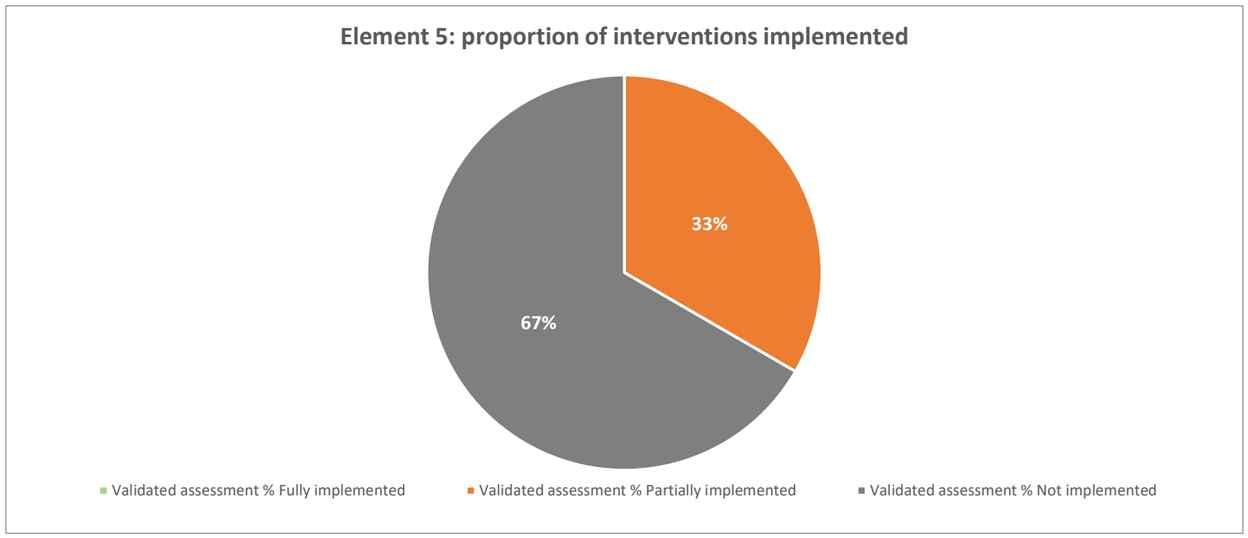
Element 4	4.1	**Not implemented**	**Not implemented**	04/08/26 - Current local guidance does not include self-adminsitration of Whooley - Questionnaires not currently self-adminstered - Digital spec set up for PHQ9 (slight variation from Whooley) - MH questionnaires not currently included in routine Badgernet notes, requires additional note to be completed, not currently mandatory - Concerns raised by national network of MH Midwives around use of self-adminstration and use of EPDS questionnaire 24-September-2026: Board Assessor Team Comments: Note the challenges of adding self-administration process to the digital system and that there is a plan to update the guidance, when a digital solution is identified. This results in a timescale spanning into March/April 2027. Unclear if the digital system issues are going to be resolved and if any concerns if there is an escalation route.	Digital specification update required by SystemC by 31st March 2027	SNOMED CT Code to record: 803351000000106 | Whooley depression screen score We are submitting everything that is required through MSDS for this question Ensure every booking is recorded in table: MSD101 Pregnancy and Booking Details We are submitting everything that is required through MSDS for this question Ensure that the administration of the Whooley questionnaire is recorded: SNOMED CT Code to record: 803351000000106 | Whooley depression screen score We are submitting everything that is required through MSDS for this question Ensure every care contact is recorded. The date of care contact activity will be captured as a mandatory data item in MSD201 Care Contact (Pregnancy), which will be used to determine if it occurred at the 25-28 week appointment. We are submitting everything that is required through MSDS for this question The date of care contact activity will be captured as a mandatory data item in MSD201 Care Contact (Pregnancy), which will be used to determine if it occurred at the 31-34 week appointment. We are submitting everything that is required through MSDS for this question	Escalation to Trust BI Team and SystmC
					Undertake audit of current MH questionnaire recording by 31st Dec 2026		
					Education and training plan with midwives to administer questionnaire at specified timepoints by 31st March 2027		Requires confirmation of appropriate digital spec prior to commencing training, esclated to Trust BI and SystmC
					Update local guidance on self-adminstration of Whooley once digital spec implemented by March 2027		
	4.2	**Not implemented**	**Not implemented**	04/08/26 - Concerns raised by national network of MH Midwives around use of self-adminstration and use of EPDS questionnaire - EPDS not currently part of digital specification, requires SystemC update 24-September-2026: Board Assessor Team Comments: Note the challenges of adding self-administration process to the digital system and that there is a plan to update the guidance, when a digital	Digital specification update required by SystemC by 31st March 2027	Ensure that the administration of the EPDS is recorded: SNOMED CT Code to record: 450320001 | Edinburgh postnatal depression scale score	
					Training plan for midwifery use of EPDS once digital specification actions implemented by 31/3/27		
	4.3	**Partially implemented**	**Not implemented**	04/08/26 - Staff already undertaking compassionate conversations to discuss needs, care options, next steps and referrals in repsonse to current MH questionnaires - EPDS not currently part of Badgernet MH questionnaires - Training required for all midwives in use of EPDS 24-September-2026: Board Assessor Team Comments: Whilst there is clinic time available to enable this,	Digital specification update required by SystemC by 31/3/27		
					Design feedback mechanism to monitor service user experience of compassionate conversations and mental health questionnaire use in pregnancy by 31st march 27		



Element 5: Obstetric haemorrhage

Element 5

Intervention Ref	Self-Assessment Status	Trust Board Validated Assessment Status	**Rationale for Trust Board Validated Assessment Status:** If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Progress	**Escalations required** (If required, specify who and what)
5.1	Partially implemented	Partially implemented	24-September-2026: Board Assessor Team Comments: PPH Guideline covers off the importance of measuring blood loss and details, within an appendix equipment needed, in line with MCB intervention to ensure accurate measurement. The PPH guideline provides guidance on action in response to PPH.	Review PPH guideline to confirm all requirements are included by 1st Oct 26	Review of all guidance completed, minor amendments made and approved at guideline group, awaiting publictaion	
5.2	Not implemented	Not implemented	4/8/26 PPH reviews currently include blood loss over 1500ml and do not routinely report on escalation at each threshold or evidence of cumultative blood loss at multiple points during emergency 24-September-2026: Board Assessor Team Comments: No evidence provided. Note actions in place to progress with these points. Timescales appear appropriate.	Design and undertake quarterly snapshot audit of 10 consecutive cases between 1000ml and 2000ml and include in quarterly report by 1st October 2026	18/8/26 Jul-Sep Q2 26/27 audit underway, quarterly report due in October	
				Develop audit tool by 1st Oct 27 to assist in PPH reviews to include - evidence of cumulative blood loss measurement	18/8/26 Audit tool being trialled at during Q2 26/27	
5.3	Not implemented	Not implemented	24-September-2026: Board Assessor Team Comments: No evidence provided. Note actions in place to progress with these points. Timescales appear appropriate.	Request weekly report from blood bank re cryo use		
				Include evidence of MDT reviews in Quarterly report		

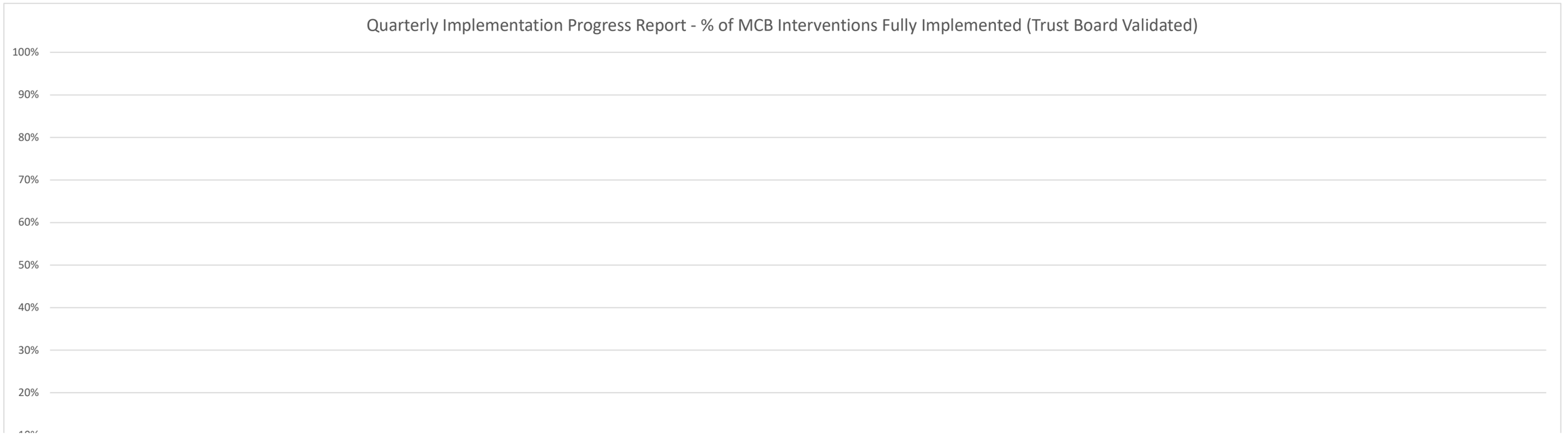

Element 5: proportion of interventions implemented
33%
67%
Validated assessment % Fully implemented
Validated assessment % Partially implemented
Validated assessment % Not implemented

Trust Board Quarterly Maternal Care Bundle Implementation Record

Trust: **United Lincolnshire Hospitals NHS Trust**

ICB: **Midlands**

	Baseline Assessment	Quarterly assessment 1	Quarterly assessment 2	Quarterly assessment 3	Quarterly assessment 4	Quarterly assessment 5	Quarterly assessment 6	Quarterly assessment 7	Quarterly assessment 8	Quarterly assessment 9	Quarterly assessment 10	Quarterly assessment 11
Review Quarter	**Q2 26/27**											
Progress Review Date	**17/09/2026**											
Element 1	0%											
Element 2	0%											
Element 3	0%											
Element 4	0%											
Element 5	0%											
TOTAL	0%											




10%
0%
Element 1
Element 2
Element 3
Element 4
Element 5
TOTAL
17/09/2026

Code	Title	Type	Discussion	Comment
MCB1.1	Maternal Medicine Pathway Standard Operating Procedure	Guideline/Policy		
MCB 2.1	EMAS Phone LCH Labour Ward	Photo	Dedicated phone line on each labour ward as requested by EMAS	
MCB 2.2	EMAS Phone PHB Labour Ward	Photo	Dedicated phone line on each labour ward as requested by EMAS	
MCB 2.3	Prehospital Maternity Decision Tool	EMAS Document	Printed copies of this available in both Labour Wards, to be incorporated into draft local SOP	
MCB 2.4	Maternal Medicine Pathway SOP	SOP	Current maternal medicine SOP in place but requires review and update by Lead Consultant and EMMMN to meet full standard, see action plan	
MCB 3.1	Management of Women with Epilepsy and Non-Epileptic Attack Disorder in Pregnancy	Guideline/Policy		
MCB 3.2	Maternal Medicine Pathway Standard Operating Procedure			
MCB 3.3	Epilepsy Maternity Self-Assessment Toolkit v2.0	Benchmarking Document	Epilpesy Trust have supplied this benchmarking tool which we have completed and returned to them as request, this will generate a support offer to help with making a plan for full implmentation	
MCB 5.1	Postpartum Haemorrhage (PPH)	Guideline/Policy	Currently being update to meet standards	
MCB 5.2	Enhancd Maternity Care - Maternal crtierai for Admission to Level 1-2 Care	Guideline/Policy	Currently being update to meet standards	
MCB 5.3	Homebirth	Guideline/Policy	Currently being update to meet standards	

Element 1 – Venous thromboembolism (VTE)

Element description: Reducing thrombotic events in early pregnancy by risk assessing all pregnant women at the earliest opportunity before antenatal booking and providing rapid access to thromboprophylaxis for those identified at high risk.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
1.1	Women should be offered the national self-assessment questionnaire on VTE risk at first NHS care contact with a positive pregnancy test. Those identified as being at high risk of VTE should be offered low molecular weight heparin (LMWH) and receive it within 72 hours*. The risk factors are: • previous confirmed diagnosis of VTE • hyperemesis gravidarum causing dehydration or immobility (that is, a woman cannot drink without vomiting or struggles to stand up and walk due to symptoms) • body mass index (BMI) greater than 50 The national self assessment questionnaire also asks: • Are you currently taking one of these anticoagulants: warfarin, apixaban, rivaroxaban, dabigatran or edoxaban? • Have you been diagnosed with antithrombin deficiency (a disorder that makes blood clots more likely)? * See supporting guidance in Maternal Care Bundle on 'abortion services' for women considering an abortion.	**MCB process indicator 1.1a** Maternity services have incorporated the early pregnancy VTE risk assessment questions into antenatal referral forms.	N/A	N/A	N/A	N/A
		MCB process indicator 1.1b All secondary care settings have embedded, or an agreed plan to embed, the early pregnancy VTE risk assessment into secondary care EPRs, including a prompt when pregnancy is discovered.	N/A	N/A	N/A	N/A
		MCB process indicator 1.2a Pathways have been agreed with primary care, emergency departments and early pregnancy assessment units for the prescribing of LMWH heparin in early pregnancy.	N/A	N/A	N/A	N/A

Element 1 – Venous thromboembolism (VTE)

Element description: Reducing thrombotic events in early pregnancy by risk assessing all pregnant women at the earliest opportunity before antenatal booking and providing rapid access to thromboprophylaxis for those identified at high risk.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
1.2	The ICB has arrangements in place for LMWH to be prescribed in early pregnancy (that is, before antenatal booking) within 72 hours, and for a follow-up consultation to take place within 4 weeks in secondary care*. * See supporting guidance in Maternal Care Bundle on 'abortion services' for women considering an abortion.	**MCB process measure 1.2b** Percentage of women who had an early pregnancy risk factor for VTE noted in their record, that were prescribed LMWH before the booking appointment.	Routine maternity data. Not currently reported in MSDS v2.0. National programme team working to implement regular reporting as part of MSDS v2.5.	**Numerator:** Number of women who had a booking appointment in the last quarter, and who had an early pregnancy risk factor for VTE noted in their records; that were prescribed LMWH ***before*** the booking appointment. **Denominator:** Number women who had a booking appointment in the last quarter, and who had an early pregnancy risk factor for VTE noted in their records. **Guidance:** An 'early pregnancy risk factor for VTE' is as defined in intervention 1.1 Please note that a seperate, more detailed risk assessment for VTE is undertaken from the booking appointment onwards, in line with RCOG GTG 37a. This measure is intended to assess the identification of risk factors through use of the early pregnancy risk assessment, and the issuing of a prescription ***before*** the booking appointment. However, local data recording practice may mean that a woman's digital record is first created at the booking appointment. This measure therefore looks at information recorded before and at the booking appointment, to help determine whether a woman had an early pregnancy risk factor.	Ensure that the early pregnancy risk factors for VTE are recorded in the following way: ***Previous confirmed diagnosis of VTE:*** SNOMED CT Code to record: **128053003 | Deep venous thrombosis (disorder)** Field to complete: **PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)** and **DIAGNOSIS DATE,** in table: **MSD107 Medical History (Previous Diagnosis)** ***Hyperemesis gravidarum causing dehydration or immobility:*** SNOMED CT Code to record: **129598007 | Severe hyperemesis gravidarum (disorder)** Field to complete: **DIAGNOSIS (CODED CLINICAL ENTRY)** and **DIAGNOSIS DATE,** in table: **MSD106 Diagnosis (Pregnancy)** ***Body mass index (BMI) greater than 50:*** SNOMED CT Code to record: **50373000 | Body height measure (observable entity)** and **27113001 | Body weight (observable entity)** Fields to complete: **CODED OBSERVATION (CLINICAL TERMINOLOGY)** and **OBSERVATION VALUE** and **UCUM UNIT OF MEASUREMENT** In table: **MSD202 Care Activity (Pregnancy)** Ensure weight is recorded in 'g' or 'kg', and height in 'cm' or 'm'. ***For all risk factors:*** The date of this activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at or before booking. Prescription data not currently reported in MSDS v2.0. National programme team working to implement regular reporting as part of MSDS v2.5.	Ensure that the early pregnancy risk factors for VTE are recorded in the following way: ***Previous confirmed diagnosis of VTE:*** SNOMED CT Code to record: **128053003 | Deep venous thrombosis (disorder)** Field to complete: **PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)** and **DIAGNOSIS DATE** In table: **MSD107 Medical History (Previous Diagnosis)** ***Hyperemesis gravidarum causing dehydration or immobility:*** SNOMED CT Code to record: **129598007 | Severe hyperemesis gravidarum (disorder)** Field to complete: **DIAGNOSIS (CODED CLINICAL ENTRY)** In table: **MSD106 Diagnosis (Pregnancy)** ***Body mass index (BMI) greater than 50:*** SNOMED CT Code to record: **50373000 | Body height measure (observable entity)** and **27113001 | Body weight (observable entity)** Fields to complete: **CODED OBSERVATION (CLINICAL TERMINOLOGY)** and **OBSERVATION VALUE** and **UCUM UNIT OF MEASUREMENT** In table: **MSD202 Care Activity (Pregnancy)** Ensure weight is recorded in 'g' or 'kg', and height in 'cm' or 'm'. ***For all risk factors:*** The date of this activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at or before booking.
1.3	Women identified as being at high risk of VTE and not already taking clot preventing medication should be offered a standardised dose of LMWH (see standardised dosing of LMWH in Maternal Care Bundle Element 1).	**MCB process indicator 1.3a** An agreed pathway or protocol is in place for the timely monitoring of responses to VTE questionnaires and referral of high-risk women to a prescriber with guidelines on standardised dosing of LMWH.	N/A	N/A	N/A	N/A

Element 1 – Venous thromboembolism (VTE)

Element description: Reducing thrombotic events in early pregnancy by risk assessing all pregnant women at the earliest opportunity before antenatal booking and providing rapid access to thromboprophylaxis for those identified at high risk.

Inter-vention Ref	Required MCB Intervention	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Date of last review	Date of next review	Action owner	Progress	Escalations required (If required, specify who and what)
1.1	Women should be offered the national self-assessment questionnaire on VTE risk at first NHS care contact with a positive pregnancy test. Those identified as being at high risk of VTE should be offered low molecular weight heparin (LMWH) and receive it within 72 hours*. The risk factors are: • previous confirmed diagnosis of VTE • hyperemesis gravidarum causing dehydration or immobility (that is, a woman cannot drink without vomiting or struggles to stand up and walk due to symptoms) • body mass index (BMI) greater than 50 The national self assessment questionnaire also asks: • Are you currently taking one of these anticoagulants: warfarin, apixaban, rivaroxaban, dabigatran or edoxaban? • Have you been diagnosed with antithrombin deficiency (a disorder that makes blood clots more likely)?	Not implemented	04/08/2026 - No current pathway for these risk factors - Digital system not currently setup for this process 18-Sept-26: Board Assessor Team Comments: Actions described (on E1 Action Plan) that outline SOP for pathway to identify and act on risk factors and escalation to the Digitial System to enable this. Timescales for SOP to support pathway are 31 March 2027. It would be useful to understand if this could be delivered sooner, as presumably the pathway can be defined whilst waiting on progress with the Digital System.	Escalation to SystmC regarding need for digital specification, also being escalated by East Midlands Maternal Medicine Network by 1st October 2026	04/08/2026		Digital Matron (PM)	For Previous confirmed diagnosis of VTE: We are not submitting 128053003 | Deep venous thrombosis (disorder). This has been escalated to the BI Lead that works with Maternity on 27/7/26	Escalation of unreported SNOMED codes to ULTH BI unit and SystmC as required
				Develop draft SOP for maternity pathway for women completing self-assessment via SPA referral by 31st march 2027	04/08/2026		AN Matron (KL) & Consultant Midwife (JB)	18/8/26 In progress	No funding or resource at present to support obstetric prescribing in early pregnancy
				Development of patient resources to support informed decision making by 31st March 2027	04/08/2026		Cons MW (JB)	18/8/26 In progress	
				Audit to determine expected numbers of women eligible for pathway by 31st march 2027	04/08/2026		Audit Midwife (SH)	18/8/26 In progress	
1.2	The ICB has arrangements in place for LMWH to be prescribed in early pregnancy (that is, before antenatal booking) within 72 hours, and for a follow-up consultation to take place within 4 weeks in secondary care*.	Not implemented	4/8/26 - This action sits with the ICB. There are no updates currently available from ICB 18-Sept-26: Board Assessor Team Comments: Actions described (on E1 Action Plan) are to await update. Deadline is not aritculated. It would be useful to understand escalation mechanisms and when this is triggered to ensure timescale pace.	Await update from ICB	04/08/2026		ICB	Informal intelligence received that this action is being reviewed by national team to confirm ownership.	ICB required to complete this action, no updates at present
			18-Sept-26: Board Assessor Team Comments: There is currently limited detail on what actions are required to implement this as part of the	See Intervention 1.1					

Element 2 – Pre-hospital and acute care

Element description: Ensuring unwell pregnant women receive the right care at the right time through improving access to urgent obstetric and maternal medicine care; and implementing a common approach to the monitoring, identification and management of maternal deterioration across all care settings.

Inter-vention Ref	Required MCB Intervention	Process Indicator or Process Measure	Agreed target performance level by March 2027	Evidence Name / Reference	Evidence Type	Reported Result Q1 26/27	Reported Result Q2 26/27	Reported Result Q3 26/27	Reported Result Q4 26/27	Reported Result Q1 27/28	Reported Result Q2 27/28	Reported Result Q3 27/28	Reported Result Q4 27/28	Self-Assessment Status	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why? Include resolution in E2 action plan worksheet
2.1	Implement the national maternity early warning score (MEWS) tool across all settings for women who are or have been pregnant in the past 4 weeks. This means ensuring timely obstetric team and/or obstetric physician review in line with the MEWS escalation timeframes, according to the total score identified and relevant additional concerns.	**MCB process indicator 2.1a** The national MEWS has been embedded into Maternity Information Systems or Electronic Patient Record with MEWS being generated for every set of observations carried out on patients admitted to maternity settings.*	N/A	MCB 2.5 Maternity EPR Implementation & RAID Log	Other	0%								**Not implemented**	**Not implemented**	04/08/26 2.1a Current electronic observtaions system does not support NMEWS parameters in maternity settings 2.1b Current electronic observations system does not support NMEWS parameters in non-maternity settings 2.1c NMEWS SOP in development in preparation for launch in October 2.1d Unable to audit with current systems, to commence with launch of nervecentre 23-Sept-26: Board Assessor Team Comments: Note the actions in place to progress this during October 2026. Action timescales seem appropriate and stretching. It would be helpful to understand if the current electronic observation system will be configurable, or if this is likely to be more challenging, and if so, what the escalation plans are.
						0%										
						0%										
						0%										
		MCB process indicator 2.1b All secondary care settings have embedded, or have an agreed plan to embed, the national MEWS into all acute secondary care EPRs, in line with the national MEWS digital specification.	N/A	MCB 2.5 Maternity EPR Implementation & RAID Log	Other	0%										
						0%										
						0%										
						0%										
		MCB process indicator 2.1c A local standard operating procedure is in place outlining the intended use, compliance of completion (physiology and additional concerns) and associated escalation according to the thresholds and triggers of the national MEWS.				0%										
						0%										
						0%										
		MCB process measure 2.1d Percentage of pregnant or recently pregnant women admitted outside a maternity setting where the MEWS tool was used in that care setting.				0%										
						0%										
						0%										
						0%										
2.2	Implement a standardised pre-alert communication system between the ambulance service and labour ward and ensure adequate signage for all labour wards so that ambulance services can convey women with an obstetric emergency or red flags promptly and appropriately.	**MCB process indicator 2.2a** A pre-alert system and associated local protocol / standard operating procedure is in place for each labour ward.	N/A	MCB 2.2 EMAS Phone LCH Labour Ward	Other	0%								**Partially implemented**	**Partially implemented**	04/08/26 - Pre-alert system in place with dedicated phone line - SOP required - Signage review completed and works underway to improve, for action plan 23-Sept-26: Board Assessor Team Comments: Dedicated phone line in place with SOP to guide pre-hospital decision making. Its not clear from the SOP as to is this available to EMAS to follow on scene, or is this SOP followed by staff receiving pre-alert? Some of the SOP talks about transport actions, presumably EMAS will need to make these decisions with this SOP at hand? The draft Pre-alert SOP clarifies that this is to guide clinicians in the community and is not designed for Maternty staff. No evidence of signage review provided. Note the action to have a plan with estates by 1 October 2026.
				MCB 2.2 EMAS Phone PHB Labour Ward	Other	0%										
				MCB 2.3 Prehospital Maternity Decision Tool	Other	0%										
						0%										
		MCB process indicator 2.2b A review of signage has been completed for every labour ward involving ambulance staff and, where issues are identified, an action plan put in place to rectify.	N/A			0%										
						0%										
						0%										
						0%										

Element 2 – Pre-hospital and acute care

Element description: Ensuring unwell pregnant women receive the right care at the right time through improving access to urgent obstetric and maternal medicine care; and implementing a common approach to the monitoring, identification and management of maternal deterioration across all care settings.

Inter-vention Ref	Required MCB Intervention	Process Indicator or Process Measure	Agreed target performance level by March 2027	Evidence Name / Reference	Evidence Type	Reported Result Q1 26/27	Reported Result Q2 26/27	Reported Result Q3 26/27	Reported Result Q4 26/27	Reported Result Q1 27/28	Reported Result Q2 27/28	Reported Result Q3 27/28	Reported Result Q4 27/28	Self-Assessment Status	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why? Include resolution in E2 action plan worksheet
2.3	Establish acute referral pathways from local services to the maternal medicine centre (MMC) for acutely unwell pregnant or recently pregnant women presenting with symptoms or diagnostic uncertainty necessitating maternal medicine expertise. Maternity services and the maternity medicine network (MMN) should review these pathways annually.	**MCB process indicator 2.3a** Local clinical guidelines or protocols are in place from all acute settings to MMC for red flag symptoms with clinical uncertainty, that have been agreed with the MMC in the past 12 months.	N/A	MCB 2.4 Maternal Medicine Pathway SOP	Standard operating procedure	0%								Partially implemented	Not implemented	04/08/26 - Plan to review current Maternal Medicine Pathway SOP to include acutely unwell women 24-Sept-26: Board Assessor Team Comments: There is a plan to update the current SOP to include this element, with a timescale of the 1
						0%										
						0%										
						0%										
		MCB process indicator 2.3b Pathways agreed from acute settings to MMC have been reviewed with the MMN within the past 12 months.	N/A	No yet actioned		0%										
						0%										
						0%										

Element 3 – Epilepsy in pregnancy

Element description: Improving control of seizures by ensuring timely access to specialist multidisciplinary epilepsy care during and after pregnancy.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
3.1	Every pregnant woman with epilepsy has access to a local epilepsy in pregnancy team who will ordinarily lead the early pregnancy, intrapartum and postnatal care plans in line with the local maternal medicine network's (MMN) management and escalation protocol. The local team will consist of, at a minimum: • epilepsy nurse specialist or neurologist • maternal medicine obstetrician (see national service specification for maternal medicine networks*) • obstetric physician (subject to local availability) *National service specification for maternal medicine networks	**MCB process indicator 3.1a** A local guideline or protocol is in place that sets out the local epilepsy team's staffing in line with intervention 3.1, clinic schedule and referral pathways available from time of referral to antenatal care, which has been agreed by clinical leads in maternity and neurology, and the Maternal Medicine Network.	N/A	N/A	N/A	N/A
3.2	Women requiring more complex epilepsy care should be referred by the local epilepsy in pregnancy team to a maternal medicine network (MMN) multidisciplinary team (MDT) who can oversee and – where necessary – lead the provision of care.	**MCB process indicator 3.2a** A local guideline or protocol is in place for the local epilepsy pregnancy team, that sets out criteria and process for referral to MMC, in line with MMC regional guidelines, which has been co-created with the MMN.	N/A	N/A	N/A	N/A
		MCB process indicator 3.2b Members of the provider's local epilepsy in pregnancy team have attended annual multidisciplinary teaching sessions about epilepsy facilitated by the MMN.	N/A	N/A	N/A	N/A

Element 3 – Epilepsy in pregnancy

Element description: Improving control of seizures by ensuring timely access to specialist multidisciplinary epilepsy care during and after pregnancy.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
-	**Expert consensus recommendation:** The element 3 working group recommends by expert consensus that services work to put in place local pathways so that every woman with epilepsy receives: • a case review and triage by a member of the local epilepsy in pregnancy team within 2 weeks of first NHS care contact with a positive pregnancy test, and that highest risk (see criteria within the Maternal Care Bundle, Element 3) women are then seen in person for medications review within a further 2 weeks (so 4 weeks from first care contact).	Median waiting time for first antenatal epilepsy appointment attended, for women self referring to maternity services with an epilepsy diagnosis.	Local maternity data	**Metric construction:** Median number of days from self-referral to antenatal care to first antenatal epilepsy appointment attended, for; • women who declared an epilepsy diagnosis at self-referral and, • in the past quarter received their first antenatal epilepsy appointment. **Guidance:** The intention of this measure is to baseline performance in providing an essential and time-critical clinical activity for pregnant women with epilepsy. This data can be used for the purposes of local quality improvement.	As a matter of best practice, attendance at local epilepsy in pregnancy MDTs should be recorded in both the maternity and secondary care records. Ensure an epilepsy diagnosis is recorded in the following way: SNOMED CT Code to record: **84757009 | Epilepsy (disorder)** Field to complete: **DIAGNOSIS (CODED CLINICAL ENTRY)** and **DIAGNOSIS DATE** in table: **MSD106 Diagnosis (Pregnancy)** Ensure an antenatal epilepsy appointment is recorded in the following way: SNOMED CT Code to record: **185230000 | Seen in neurology clinic (finding)** Fields to complete: **CODED FINDING (CODED CLINICAL ENTRY)** In table: **MSD202 Care Activity (Pregnancy)** The date of this activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**. The date of self-referral is captured in **MSD101 Pregnancy and Booking Details**.	N/A - see numerator
		A protocol or pathway is in place for self-referrals to maternity services to be reviewed, and women reporting epilepsy to be referred to local epilepsy pregnancy team for case review.	N/A	N/A	N/A	N/A

Element 3 – Epilepsy in pregnancy

Element description: Improving control of seizures by ensuring timely access to specialist multidisciplinary epilepsy care during and after pregnancy.

Inter-vention Ref	Required MCB Intervention	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Date of last review	Date of next review	Action owner	Progress	Escalations required (If required, specify who and what)
3.1	Every pregnant woman with epilepsy has access to a local epilepsy in pregnancy team who will ordinarily lead the early pregnancy, intrapartum and postnatal care plans in line with the local maternal medicine network's (MMN) management and escalation protocol. The local team will consist of, at a minimum: • epilepsy nurse specialist or neurologist • maternal medicine obstetrician (see national service specification for maternal medicine networks*) • obstetric physician (subject to local availability)	Partially implemented	04/08/26 - Joint clinic established in both antenatal clinics however guidance and processes require review to ensure full compliance with MCB requirements - Obstetric epilepsy support not currently included in epilepsy commissioing 24-September-2026: Board Assessor Team Comments: 'MCB 3.3 Epilepsy Maternity Self Assessment Toolkit v2.0' evidence demonstrates that a local epilepsy in pregnancy team is in place. The Epilepsy SOP defines how the team can be contacted and interacted with.	Undertake audit of current practice over last 12 months by 1/11/26	04/08/2026		Patient Safety MW (ST)	18/8/26 Underway	
				Review evidence of Epilepsy Nurse CPD for management of epilepsy in pregnancy by 1/11/26	04/08/2026		Epilepsy Nurse (TT)	18/8/26 To be confirmed	
				Confirm availability of Maternal Medicine Network epilepsy in pregnancy training by 1/11/26	04/08/2026		Cons Obs for Epilepsy (MS & CF)	18/8/26 To be confirmed	
				Review commissioning of epilepsy nurses to support joint clinic by 31/3/26	04/08/2026		Cons MW (JB)	18/8/26 To be confirmed	ULTH Epilepsy service not currently commissioned to provide joint obstetric/epilepsy clinics, requires Trust level review of service to ensure provision of epilepsy services within joint clinics and to
3.2	Women requiring more complex epilepsy care should be referred by the local epilepsy in pregnancy team to a maternal medicine network (MMN) multidisciplinary team (MDT) who can oversee and – where necessary – lead the provision of care.	Partially implemented	04/08/26 - Largely compliant but need to review current guidance to ensure all required details are included in referrals 24-September-2026: Board Assessor Team Comments: 'Management of women with Epilepsy SOP' describes referral criteria to MMM. No evidence of attending training provided.	Complete Epilepsy Trust Benchamrking exercise by 14th Sep 26	04/08/2026		Patient Safety MW (ST)	18/8/26 Underway 10/9/26 Completed and returned to Epilepsy Trust to access Support Offer	
				Review digital specification of badgernet Maternal Medicine Note for documentation of joint neurology documentation and coding of clinics by 31/12/26	04/08/2026		Digital Matron (PM)	Ensure an epilepsy diagnosis is recorded in the following way: We are not submitting 84757009 | Epilepsy (disorder) This has been escalated to the BI Lead that works with Maternity on 22/7/26	Current digital sepcification does not include SNOMED as listed in E3 measures, requires SystemC update
	Expert consensus recommendations		04/08/26	Agree criteria and pathway with Epilepsy nurse team, to complete as part of Epilepsy Trust benchmarking submission	04/08/2026		Safety Lead MW (ST) and Epilepsy Nurse (TT)	18/8/26 Benchmarking underway	

Element 4 – Maternal mental health

Element description: Improving the identification and response to perinatal mental health concerns through the consistent use of NICE recommended screening tools and timely referral to appropriate specialist support.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
4.1	As part of routine emotional wellbeing screening, women should be invited to **self-administer** the Whooley questions ahead of the: • booking, 25–28 week and 31–34 week antenatal appointments; and • 10–14 day postnatal appointment	**MCB process indicator 4.1a** A local protocol or guideline is in place on the self-administration of Whooley questions at booking, 25-28 week, 31-34 week appointments and 10-14 day postnatal appointment.	N/A	N/A	N/A	N/A
		MCB process measure 4.1b Percentage of women who had a Whooley questionnaire score recorded at booking appointment.	Recording of Whooley questionnaire administration for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who had a booking appointment in the past quarter who had a Whooley questionnaire score recorded at booking. **Denominator:** Number of women who had a booking appointment in the past quarter.	Ensure that the administration of the Whooley questionnaire is recorded: SNOMED CT Code to record: **803351000000106 | Whooley depression screen score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)** The date of this activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at booking.	Ensure every booking is recorded in table: **MSD101 Pregnancy and Booking Details**
		MCB process measure 4.1c Percentage of women who had a Whooley questionnaire score recorded 25-28 week antenatal appointment.	Recording of Whooley questionnaire administration for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who had a 25-28 week appointment in the past quarter who had a Whooley questionnaire score recorded 25-28 week appointment. **Denominator:** Number of women who had a 25-28 week appointment in the past quarter.	Ensure that the administration of the Whooley questionnaire is recorded: SNOMED CT Code to record: **803351000000106 | Whooley depression screen score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)** The date of this activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at the 25-28 week appointment.	Ensure every care contact is recorded. The date of care contact activity will be captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at the 25-28 week appointment.
		MCB process measure 4.1d Percentage of women who had a Whooley questionnaire score recorded at 31-34 weeks antenatal appointment.	Recording of Whooley questionnaire administration for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who had a 31-34 week appointment in the past quarter who had a Whooley questionnaire score recorded at the 31-34 week appointment. **Denominator:** Number of women who had a 31-34 week appointment in the past quarter.	Ensure that the administration of the Whooley questionnaire is recorded: SNOMED CT Code to record: **803351000000106 | Whooley depression screen score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)** The date of this activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at the 31-34 week appointment.	Ensure every care contact is recorded. The date of care contact activity will be captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at the 31-34 week appointment.

Element 4 – Maternal mental health

Element description: Improving the identification and response to perinatal mental health concerns through the consistent use of NICE recommended screening tools and timely referral to appropriate specialist support.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
4.2	When a woman responds positively to either of the Whooley questions or there is concern, she should be invited to complete a further assessment using the Edinburgh Postnatal Depression Scale (EPDS). Where appropriate, this could be by self-administration.	**MCB process measure 4.1e** Percentage of women who had a Whooley questionnaire score recorded at 10-14 days postnatal appointment.	Recording of Whooley questionnaire administration for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who had a 10-14 day postnatal appointment in the past quarter who had a Whooley questionnaire score recorded at the 10-14 day postnatal appointment. **Denominator:** Number of women who had a 10-14 day postnatal appointment in the past quarter.	Ensure that the administration of the Whooley questionnaire is recorded: SNOMED CT Code to record: **803351000000106 | Whooley depression screen score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD203 Coded Scored Assessment (Contact)** or **MSD203 Coded Scored Assessment (Contact)** The date of this MSD202 activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy),** which will be used to determine if it occurred at the 10-14 days postnatal appointment.	Ensure every care contact is recorded. The date of this care contact activity is captured as a mandatory data item in **MSD201 Care Contact (Pregnancy)**, which will be used to determine if it occurred at the 10-14 days postnatal appointment.
		MCB process indicator 4.1f All maternity services have embedded Whooley into patient facing digital systems, or have a process in place for administration of paper questionnaires.	N/A	N/A	N/A	N/A
		MCB process measure 4.2a Percentage of women who screen positive in Whooley questionnaire, that subsequently had EPDS recorded within a week.	Recording of Whooley questionnaire administration and EPDS administration for each postnatal woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who had a Whooley questionnaire and screen positive score recorded in the past quarter, that subsequently had EPDS recorded within a week of the Whooley questionnaire administration. **Denominator:** Number of women who had a Whooley questionnaire and screen positive score recorded in the past quarter.	Ensure that the administration of the Whooley questionnaire and score is recorded: SNOMED CT Code to record: **803351000000106 | Whooley depression screen score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)** and Ensure that the administration of the EPDS is recorded: SNOMED CT Code to record: **450320001 | Edinburgh postnatal depression scale score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)**	Ensure that the administration of the Whooley questionnaire and score is recorded: SNOMED CT Code to record: **803351000000106 | Whooley depression screen score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)**
		MCB process indicator 4.2b A local protocol or guideline is in place on the self-administration of EPDS, where appropriate, where women respond positively to either of the Whooley questions or there is concern.	N/A	N/A	N/A	N/A

Element 4 – Maternal mental health

Element description: Improving the identification and response to perinatal mental health concerns through the consistent use of NICE recommended screening tools and timely referral to appropriate specialist support.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
		MCB process indicator 4.2c All maternity services have EPDS embedded in patient facing digital systems and in records, or a process in place for administration of paper questionnaires.	N/A	N/A	N/A	N/A
4.3	If a woman screens positive using EPDS (scores 13 or above in total or 2 or above on self-harm) or there is clinical concern, allow sufficient time in the same appointment to offer the woman a compassionate conversation to explore needs, discuss care options, agree next steps and receive referral to appropriate services if indicated.	**MCB process indicator 4.3a** A local guideline or protocol is in place that sets out local perinatal mental health teams and how to refer, which has been agreed by clinical leads in maternity and perinatal mental health.	N/A	N/A	N/A	N/A
		MCB process measure 4.3b Percentage of women that screen positive on EPDS (scores 13 or above in total or 2 or above on self-harm) who are referred for further support.	Recording of EPDS administration and referral information for each postnatal woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who had a EPDS and screen positive score recorded in the past quarter, that were referred for further support. **Denominator:** Number of women who had a EPDS and screen positive score recorded in the past quarter. **Guidance:** Further support includes any NHS adult mental health or parent-infant service that provides treatment for both parental mental health problems and parenting. This could include specialist perinatal community mental health services (or maternal mental health services), NHS Talking Therapies, Mother and Baby Unit, adult community mental health team, Early Intervention Psychosis Services, Eating Disorders Services and 'personality disorder' services.	Ensure that the administration of the EPDS is recorded: SNOMED CT Code to record: **450320001 | Edinburgh postnatal depression scale score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)** Ensure that referral for further support is recorded: SNOMED CT Code to record: **781531000000107 | Referral to community perinatal mental health team (procedure)** or **390866009 | Referral to mental health team (procedure)** or **380201000000109 | Referral to IAPT (improving access to psychological therapies) programme (procedure)** or **380241000000107 | Refer to Child and Adolescent Mental Health Service (procedure)** Fields to complete: **CODED PROCEDURE AND PROCEDURE STATUS (CODED CLINICAL ENTRY)** In table: **MSD202 Care Activity (Pregnancy)**	Ensure that the administration of the EPDS is recorded: SNOMED CT Code to record: **450320001 | Edinburgh postnatal depression scale score** Fields to complete: **CODED ASSESSMENT TOOL TYPE (SNOMED CT)** and **PERSON SCORE** and **ASSESSMENT TOOL COMPLETION DATE** In table: **MSD104 Coded Scored Assessment (Pregnancy)** or **MSD203 Coded Scored Assessment (Contact)**

Element 4 – Maternal mental health

Element description: Improving the identification and response to perinatal mental health concerns through the consistent use of NICE recommended screening tools and timely referral to appropriate specialist support.

Inter-vention Ref	Required MCB Intervention	Process Indicator or Process Measure	Agreed target performance level by March 2027	Evidence Name / Reference	Evidence Type	Reported Result Q1 26/27	Reported Result Q2 26/27	Reported Result Q3 26/27	Reported Result Q4 26/27	Reported Result Q1 27/28	Reported Result Q2 27/28	Reported Result Q3 27/28	Reported Result Q4 27/28	Self-Assessment Status	Intervention: Trust Board Validated Assessment Status	**Rationale for Trust Board Validated Assessment Status:** If intervention is not deemed fully implemented or partially implemented, why? Include resolution in E4 action plan worksheet
4.1	As part of routine emotional wellbeing screening, women should be invited to **self-administe**r the Whooley questions ahead of the: • booking, 25–28 week and 31–34 week antenatal appointments; and • 10–14 day postnatal appointment	**MCB process indicator 4.1a** A local protocol or guideline is in place on the self-administration of Whooley questions at booking, 25-28 week, 31-34 week appointments and 10-14 day postnatal appointment.	N/A			0%								Not implemented	Not implemented	04/08/26 - Current local guidance does not include self-adminsitration of Whooley - Questionnaires not currently self-adminstered - Digital spec set up for PHQ9 (slight variation from Whooley) - MH questionnaires not currently included in routine Badgernet notes, requires additional note to be completed, not currently mandatory - Concerns raised by national network of MH Midwives around use of self-adminstration and use of EPDS questionnaire 24-September-2026: Board Assessor Team Comments: Note the challenges of adding self-administration process to the digital system and that there is a plan to update the guidance, when a digital solution is identified. This results in a timescale spanning into March/April 2027. Unclear if the digital system issues are going to be resolved and if any concerns if there is an escalation route.
						0%										
						0%										
						0%										
		MCB process measure 4.1b Percentage of women who had a Whooley questionnaire score recorded at booking appointment.				0%										
						0%										
						0%										
						0%										
		MCB process measure 4.1c Percentage of women who had a Whooley questionnaire score recorded 25-28 week antenatal appointment.				0%										
						0%										
						0%										
						0%										
		MCB process measure 4.1d Percentage of women who had a Whooley questionnaire score recorded at 31-34 weeks antenatal appointment.				0%										
						0%										
						0%										
						0%										
		MCB process measure 4.1e Percentage of women who had a Whooley questionnaire score recorded at 10-14 days postnatal appointment.				0%										
						0%										
						0%										
						0%										
		MCB process indicator 4.1f All maternity services have embedded Whooley into patient facing digital systems, or have a process in place for administration of paper questionnaires.	N/A			0%										
						0%										
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						0%										

Element 4 – Maternal mental health

Element description: Improving the identification and response to perinatal mental health concerns through the consistent use of NICE recommended screening tools and timely referral to appropriate specialist support.

Inter-vention Ref	Required MCB Intervention	Process Indicator or Process Measure	Agreed target performance level by March 2027	Evidence Name / Reference	Evidence Type	Reported Result Q1 26/27	Reported Result Q2 26/27	Reported Result Q3 26/27	Reported Result Q4 26/27	Reported Result Q1 27/28	Reported Result Q2 27/28	Reported Result Q3 27/28	Reported Result Q4 27/28	Self-Assessment Status	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why? Include resolution in E4 action plan worksheet
4.2	When a woman responds positively to either of the Whooley questions or there is concern, she should be invited to complete a further assessment using the Edinburgh Postnatal Depression Scale (EPDS). Where appropriate, this could be by self-administration.	**MCB process measure 4.2a** Percentage of women who screen positive in Whooley questionnaire, that subsequently had EPDS recorded within a week.				0%								Not implemented	Not implemented	04/08/26 - Concerns raised by national network of MH Midwives around use of self-adminstration and use of EPDS questionnaire - EPDS not currently part of digital specification, requires SystemC update 24-September-2026: Board Assessor Team Comments: Note the challenges of adding self-administration process to the digital system and that there is a plan to update the guidance, when a digital solution is identified. This results in a timescale spanning into March/April 2027. Unclear if the digital system issues are going to be resolved and if any concerns if there is an escalation route.
						0%										
						0%										
						0%										
		MCB process indicator 4.2b A local protocol or guideline is in place on the self-administration of EPDS, where appropriate, where women respond positively to either of the Whooley questions or there is concern.	N/A			0%										
						0%										
						0%										
						0%										
		MCB process indicator 4.2c All maternity services have EPDS embedded in patient facing digital systems and in records, or a process in place for administration of paper questionnaires.	N/A			0%										
						0%										
						0%										
						0%										
4.3	If a woman screens positive using EPDS (scores 13 or above in total or 2 or above on self-harm) or there is clinical concern, allow sufficient time in the same appointment to offer the woman a compassionate conversation to explore needs, discuss care options, agree next steps and receive referral to appropriate services if indicated.	**MCB process indicator 4.3a** A local guideline or protocol is in place that sets out local perinatal mental health teams and how to refer, which has been agreed by clinical leads in maternity and perinatal mental health.	N/A			0%								Partially implemented	Not implemented	04/08/26 - Staff already undertaking compassionate conversations to discuss needs, care options, next steps and referrals in repsonse to current MH questionnaires - EPDS not currently part of Badgernet MH questionnaires - Training required for all midwives in use of EPDS 24-September-2026: Board Assessor Team Comments: Whilst there is clinic time available to enable this, this is not yet linked to EPDS scoring, so no evidence to demonstrate progress with escalation of EPDS scoring, as not yet in place.
						0%										
						0%										
						0%										
		MCB process indicator 4.3b Percentage of women that screen positive on EPDS (scores 13 or above in total or 2 or above on self-harm) who are referred for further support.				0%										
						0%										
						0%										

Element 4 – Maternal mental health

Element description: Improving the identification and response to perinatal mental health concerns through the consistent use of NICE recommended screening tools and timely referral to appropriate specialist support.

Inter-vention Ref	Required MCB Intervention	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Date of last review	Date of next review	Action owner	Progress	Escalations required (If required, specify who and what)
4.1	As part of routine emotional wellbeing screening, women should be invited to **self-administer** the Whooley questions ahead of the: • booking, 25–28 week and 31–34 week antenatal appointments; and • 10–14 day postnatal appointment	**Not implemented**	04/08/26 - Current local guidance does not include self-adminsitration of Whooley - Questionnaires not currently self-adminstered - Digital spec set up for PHQ9 (slight variation from Whooley) - MH questionnaires not currently included in routine Badgernet notes, requires additional note to be completed, not currently mandatory - Concerns raised by national network of MH Midwives around use of self-adminstration and use of EPDS questionnaire 24-September-2026: Board Assessor Team Comments: Note the challenges of adding self-administration process to the digital	Digital specification update required by SystemC by 31st March 2027	04/08/2026		Digital Matron (PM)	SNOMED CT Code to record: 803351000000106 | Whooley depression screen score We are submitting everything that is required through MSDS for this question	Escalation to Trust BI Team and SystmC
				Undertake audit of current MH questionnaire recording by 31st Dec 2026	04/08/2026		Mental Health MW (VC)		
				Education and training plan with midwives to administer questionnaire at specified timepoints by 31st March 2027	04/08/2026		Mental Health MW (VC)		Requires confirmation of appropriate digital spec prior to commencing training, esclated to Trust BI and SystmC
				Update local guidance on self-adminstration of Whooley once digital spec implemented by March 2027	04/08/2026		Mental Health MW (VC)		
4.2	When a woman responds positively to either of the Whooley questions or there is concern, she should be invited to complete a further assessment using the Edinburgh Postnatal Depression Scale (EPDS). Where appropriate, this could be by self-administration.	**Not implemented**	04/08/26 - Concerns raised by national network of MH Midwives around use of self-adminstration and use of EPDS questionnaire - EPDS not currently part of digital specification, requires SystemC update 24-September-2026: Board Assessor Team Comments: Note the challenges of adding self-administration process to the digital system and that there is a plan to update the guidance, when a digital solution is identified. This results in a timescale spanning into March/April 2027. Unclear if the digital system issues	Digital specification update required by SystemC by 31st March 2027	04/08/2026		Digital Matron (PM)	Ensure that the administration of the EPDS is recorded: SNOMED CT Code to record: 450320001 | Edinburgh postnatal depression scale score EPDS is not currently available in Badgernet Raised at national MCB meeting	
				Training plan for midwifery use of EPDS once digital specification actions implemented by 31/3/27	04/08/2026		Mental Health MW (VC)		
			04/08/26 - Staff already undertaking compassionate conversations to discuss needs, care options, next steps and referrals in repsonse to	Digital specification update required by SystemC by 31/3/27	04/08/2026		Digital Matron (PM)		

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
5.1	Measure cumulative blood loss for all births in community and secondary care settings. This includes ensuring access to key resources including: • scales – available at all births with swab weight chart to record and assess blood loss accurately • under-buttock blood collection drapes for assisted vaginal births • access to an obstetric haemorrhage emergency kit – that is, a trolley or grab bag for all births and postnatal settings • documentation tool for individual patient records to be updated in real time	**MCB process indicator 5.1a** A clinical guideline is in place for the cumulative quantitative measurement of blood loss during and after labour, escalation (who, what, when) in line with MCB element 5.	N/A	N/A	N/A	N/A
		MCB process measure 5.1b Percentage of women with bleed >2L with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a.	Manual audit of case reviews completed in line with intervention 5.3	**Numerator:** Number of women with bleed >2L case reviewed in the last quarter, with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a **Denominator:** Number of women with bleed >2L case reviewed in last quarter **Guidance:** This metric will derive from manual audits required as part of intervention 5.3. As part of these audits, leads should seek evidence that blood loss has been recorded at more than one time point - not just at the end of intrapartum care. This should be evidenced through routine use of a paper or electronic real-time documentation tool to cumulatively measure blood loss, that is evidenced in records.		
		MCB process measure 5.1c Percentage of women with bleed >1L and <2L with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a.	Manual audit of cases	**Numerator:** Number of women with bleed >1L and <2L, with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a **Denominator:** Number of women with bleed >1L and <2L whose cases have been reviewed **Guidance:** This should be evidenced through routine use of a paper or electronic real-time documentation tool to cumulatively measure blood loss, that is evidenced in records. Audit of blood losses of >1L and <2L are intended to improve insight into cases where a haemorrhage has been identified and a massive haemorrhage has been prevented by timely escalation and action. However, as these cases are not required to be reviewed in intervention 5.3 and are more frequent than losses >2L, trusts should agree a scale and frequency of audit that is proportionate and feasible for the clinical team. For example, this could be looking 10 consecutive cases of losses >1L and <2L in a quarter.		

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
5.2	Standardised definition and reporting of postpartum haemorrhage (PPH) and points of escalation by cumulative measured blood loss: • by 500mL loss* and ongoing bleeding: ◦for community births, escalation and help sought, with plans made for immediate transfer to secondary care. ◦ in secondary care, midwife in charge and the first-line obstetric and anaesthetic staff should be alerted • by 1,000mL loss,* senior midwife, obstetrician (ST3 equivalent or above) and anaesthetist should all be present and managing as an obstetric emergency • by 1,500mL loss,* consultant obstetricians should be informed, with attendance required if bleeding ongoing, unstable or deteriorating • standardising reporting of PPH at 1,500mL* * Clinical judgement should be used to escalate earlier if required, taking into consideration the woman's individual risk factors that may lead to an earlier deterioration and the skill mix of the clinical team attending.	**MCB process measure 5.2a** Percentage of women with bleed >2L case reviewed in previous month with evidence of timely escalations in line with clinical guideline in 5.1a.	Manual audit of case reviews completed in line with intervention 5.3	**Numerator:** Number of women with bleed >2L case reviewed in the last quarter, with evidence of timely escalations in line with clinical guideline in 5.1a **Denominator:** Number of women with bleed >2L case reviewed in last quarter **Guidance:** This should be evidenced through routine use of a paper or electronic real-time documentation tool to record timely escalations, that is evidenced in records. It should be recognised that clinical scenarios may not allow for timely, sequential escalation. Therefore, clinical judgement must be exercised to agree what escalation was possible in the circumstances of each case. Ambitions and trajectories for % reliability should be based on a root-cause analysis of missed escalations and local judgement on what percentage of cases could have been escalated in a more timely manner.		
		MCB process measure 5.2b Percentage of women with bleed >1L and <2L with evidence of timely escalations in line with clinical guideline in 5.1a.	Manual audit of cases	**Numerator:** Number of women with bleed >1L and <2L , with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a **Demoninator:** Number of women with bleed >1L and <2L whose cases have been reviewed **Guidance:** This should be evidenced through routine use of a paper or electronic real-time documentation tool to record timely escalations, that is evidenced in records. It should be recognised that clinical scenarios may not allow for timely, sequential escalation. Therefore, clinical judgement must be exercised to agree what escalation was possible in the circumstances of each case. Ambitions and trajectories for % reliability should be based on a root-cause analysis of missed escalations and local judgement on what percentage of cases could have been escalated in a more timely manner. Audit of blood losses of >1L and <2L are intended to improve insight into cases where a haemorrhage has been identified and a massive haemorrhage has been prevented by timely escalation and action. However, as these cases are not required to be reviewed in intervention 5.3 and are more frequent than losses >2L, trusts should agree a scale and frequency of audit that is proportionate and feasible for the clinical team. For example, this could be looking 10 consecutive cases of losses >1L and <2L in a quarter.		
5.3	Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month.	**MCB process measure 5.3a** Percentage of women with bleed >2L case reviewed within a month.	Manual audit of case reviews completed in line with intervention 5.3	**Numerator:** Number of women with recorded bleed >2L in a birth in the past quarter, with a case review recorded as taking place within a month. **Denominator:** Number of women with a recorded bleed >2L in a birth in the past quarter.		

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Process or Outcome Measure	Data Source	Technical Definition (for metrics)	MSDS data entry required for numerator	MSDS data entry required for denominator
-	**Expert consensus recommendations:** • Services should agree protocols with laboratories so that Clauss fibrinogen assay results are available within 1 hour of taking blood for testing in cases of coagulopathy, abruption, fetal demise, suspicion of concealed bleeding, maternal cardiac arrest, suspicion of amniotic fluid embolus or PPH >1,000mL. • Point-of-care testing (TEG/ROTEM or equivalent) is faster than standard laboratory testing, with clotting results available in minutes rather than hours. This supports early identification and correction of low fibrinogen levels and allows targeted replacement with fibrinogen products infused at a time and dose specific to the woman's need.	A service level agreement is in place with laboratory services for timely clauss fibrinogen assay results within 1 hour.	N/A	N/A	N/A	N/A
		A clinical protocol is in place for effective use of point of care coagulation testing (for each Labour Ward where in use).	N/A	N/A	N/A	N/A

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Process Indicator or Process Measure	Agreed target performance level by March 2027	Evidence Name / Reference	Evidence Type	Reported Result Q1 26/27	Reported Result Q2 26/27	Reported Result Q3 26/27	Reported Result Q4 26/27	Reported Result Q1 27/28	Reported Result Q2 27/28	Reported Result Q3 27/28	Reported Result Q4 27/28	Self-Assessment Status	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why? Include resolution in E5 action plan worksheet
5.1	Measure cumulative blood loss for all births in community and secondary care settings. This includes ensuring access to key resources including: • scales – available at all births with swab weight chart to record and assess blood loss accurately • under-buttock blood collection drapes for assisted vaginal births • access to an obstetric haemorrhage emergency kit – that is, a trolley or grab bag for all births and postnatal settings • documentation tool for individual patient records to be updated in real time	**MCB process indicator 5.1a** A clinical guideline is in place for the cumulative quantitative measurement of blood loss during and after labour, escalation (who, what, when) in line with MCB element 5.	N/A	PPH guideline	Guideline/policy	n/a								Partially implemented	Partially implemented	24-September-2026: Board Assessor Team Comments: PPH Guideline covers off the importance of measuring blood loss and details, within an appendix equipment needed, in line with MCB intervention to ensure accurate measurement. The PPH guideline provides guidance on action in response to PPH.
				Homebirth guideline	Guideline/policy	n/a										
				EMC guideline	Guideline/policy	n/a										
						n/a										
		MCB process measure 5.1b Percentage of women with bleed >2L with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a.				0%										
						n/a										
		MCB process measure 5.1c Percentage of women with bleed >1L and <2L with evidence of cumulative measured blood loss in line with clinical guideline in 5.1a.				0%										
						n/a										
5.2	Standardised definition and reporting of postpartum haemorrhage (PPH) and points of escalation by cumulative measured blood loss: • by 500mL loss* and ongoing bleeding: ◦for community births, escalation and help sought, with plans made for immediate transfer to secondary care. ◦ in secondary care, midwife in charge and the first-line obstetric and anaesthetic staff should be alerted • by 1,000mL loss,* senior midwife, obstetrician (ST3 equivalent or above) and anaesthetist should all be present and managing as an obstetric emergency • by 1,500mL loss,* consultant obstetricians should be informed, with attendance required if bleeding ongoing, unstable or deteriorating • standardising reporting of PPH at 1,500mL* * Clinical judgement should be used to escalate earlier if required, taking into consideration the woman's individual risk factors that may lead to an earlier deterioration and the skill mix of the clinical team attending.	**MCB process indicator 5.2a** Percentage of women with bleed >2L case reviewed in previous month with evidence of timely escalations in line with clinical guideline in 5.1a.				0%								Not implemented	Not implemented	4/8/26 PPH reviews currently include blood loss over 1500ml and do not routinely report on escalation at each threshold or evidence of cumulative blood loss at multiple points during emergency 24-September-2026: Board Assessor Team Comments: No evidence provided. Note actions in place to progress with these points. Timescales appear appropriate.
		MCB process measure 5.2b Percentage of women with bleed >1L and <2L with evidence of timely escalations in line with clinical guideline in 5.1a.				0%										
5.3	Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of	**MCB process indicator 5.3a**				0%								Not implemented	Not implemented	24-September-2026: Board Assessor Team Comments: No evidence provided. Note actions in place to progress with these points. Timescales appear appropriate.

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Process Indicator or Process Measure	Agreed target performance level by March 2027	Evidence Name / Reference	Evidence Type	Reported Result Q1 26/27	Reported Result Q2 26/27	Reported Result Q3 26/27	Reported Result Q4 26/27	Reported Result Q1 27/28	Reported Result Q2 27/28	Reported Result Q3 27/28	Reported Result Q4 27/28	Self-Assessment Status	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why? Include resolution in E5 action plan worksheet
5.3	significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month.	Percentage of women with bleed >2L case reviewed within a month.												Not implemented	Not implemented	
-	**Expert consensus recommendations** • Services should agree protocols with laboratories so that Clauss fibrinogen assay results are available within 1 hour of taking blood for testing. • Point-of-care testing (TEG/ROTEM or equivalent) is faster than standard laboratory testing, with clotting results available in minutes rather than hours. This supports early identification and correction of low fibrinogen levels and allows targeted replacement with fibrinogen products infused at a time and dose specific to the woman's need.	A service level agreement is in place with laboratory services for timely clauss fibrinogen assay results within 1 hour.	N/A											Not implemented	Not implemented	24-September-2026: Board Assessor Team Comments: No evidence provided. Note actions in place to progress with these points. Timescales appear appropriate.
		A clinical protocol is in place for effective use of point of care coagulation testing (for each Labour Ward where in use).	N/A													

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Date of last review	Date of next review	Action owner	Progress	Escalations required (If required, specify who and what)
5.1	Measure cumulative blood loss for all births in community and secondary care settings. This includes ensuring access to key resources including: • scales – available at all births with swab weight chart to record and assess blood loss accurately • under-buttock blood collection drapes for assisted vaginal births • access to an obstetric haemorrhage emergency kit – that is, a trolley or grab bag for all births and postnatal settings • documentation tool for individual patient records to be updated in real time	Partially implemented	24-September-2026: Board Assessor Team Comments: PPH Guideline covers off the importance of measuring blood loss and details, within an appendix equipment needed, in line with MCB intervention to ensure accurate measurement. The PPH guideline provides guidance on action in response to PPH.	Review PPH guideline to confirm all requirements are included by 1st Oct 26	04/08/2025	07/10/2026	Safety Lead (AMC)	Review of all guidance completed, minor amendments made and approved at guideline group, awaiting publictaion	
	Standardised definition and reporting of postpartum haemorrhage (PPH) and points of escalation by cumulative measured blood loss: • by 500mL loss* and ongoing bleeding: ◦for community births, escalation and help sought, with plans made for immediate transfer to secondary care. ◦ in secondary care, midwife in charge and the first-line obstetric and anaesthetic staff should be alerted • by 1,000mL loss,* senior midwife, obstetrician (ST3 equivalent or above) and anaesthetist should all be present and managing as an obstetric emergency • by 1,500mL loss,* consultant obstetricians should be informed, with attendance required if bleeding ongoing, unstable or deteriorating • standardising reporting of PPH at 1,500mL* *Clinical judgement should be used to escalate earlier if required, taking into consideration the woman's individual risk factors that may lead to an earlier deterioration and the skill mix of the clinical team attending.			Design and undertake quarterly snapshot audit of 10 consecutive cases between 1000ml and 2000ml and include in quarterly report by 1st October 2026	04/08/2025	07/10/2026	Safety Lead (AMC)	18/8/26 Jul-Sep Q2 26/27 audit underway, quarterly report due in October	
5.2		Not implemented	4/8/26 PPH reviews currently include blood loss over 1500ml and do not routinely report on escalation at each threshold or evidence of cumultative blood loss at multiple points during emergency 24-September-2026: Board Assessor Team Comments: No evidence provided. Note actions in place to progress with these points. Timescales appear appropriate.	Develop audit tool by 1st Oct 27 to assist in PPH reviews to include - evidence of cumulative blood loss measurement - appropriate esclation at each blood loss threshold - evidence of review in month following incident	04/08/2025	07/10/2026	Safety Lead (AMC)	18/8/26 Audit tool being trialled at during Q2 26/27	
				Request weekly report from blood bank re cryo use	04/08/2025	07/10/2026	Safety Lead (AMC)		
				Include evidence of MDT reviews in Quarterly report	04/08/2026	07/10/2026	Safety Lead (AMC)		
5.3	Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of	Not implemented							

Element 5 – Obstetric haemorrhage

Element description: Improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning.

Inter-vention Ref	Required MCB Intervention	Intervention: Trust Board Validated Assessment Status	Rationale for Trust Board Validated Assessment Status: If intervention is not deemed fully implemented or partially implemented, why?	SMART actions to achieve full compliance	Date of last review	Date of next review	Action owner	Progress	Escalations required (If required, specify who and what)
5.3	significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month.	Not implemented							
	Expert consensus recommendations			Confirm SLA with Blood Transfusion Services by 1st Oct 26	04/08/2026	07/10/2026	Safety Lead (AMC)		

NHS
Lincolnshire Community and Hospitals NHS Group

Thirlwall Report

Briefing of report implications to ULTH

Caring and building a healthier future for all

Meeting	Lincolnshire Community and Hospitals Group Board
Date of meeting	3 November 2026
Agenda item number	8.2
Report title	Thirlwall Report: Briefing of Report Implications to ULTH
Report Purpose:	This report is provided for information and assurance
Accountable Director	Nerea Odongo, Group Chief Nurse
Author(s)	Kate Rivett, Nurse Director, Children and Young People
Financial implications, if applicable	Unknown
Action / decision required	Trust Board is asked to note the content of this report.

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	
3b: Move from prescription to prevention, through a population health management & health inequalities approach	
3c (i): Enhance our digital capability through innovation delivering the 10 year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	

3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities

Executive Summary

In August 2023, Lucy Letby, a former neonatal nurse at the Countess of Chester Hospital, was convicted of the murder of seven infants and the attempted murder of six others. An additional conviction for the attempted murder of a further infant was secured at a retrial in July 2024.

Following these convictions, the UK Government established the Thirlwall Inquiry, an independent statutory public inquiry chaired by Lady Justice Thirlwall. The purpose of the Inquiry was not to revisit the criminal proceedings, but to examine the circumstances surrounding the events at the Countess of Chester Hospital and to identify lessons for the wider NHS.

Specifically, the Inquiry considered how concerns relating to unexpected neonatal deaths and deteriorations were identified, escalated and acted upon; the responses of clinicians, managers and executive leaders when concerns were raised; whether opportunities existed to intervene sooner; the experiences of affected families; and the effectiveness of NHS governance arrangements, regulatory oversight, whistleblowing processes and patient safety systems.

Following publication of the *Report for the Thirlwall Inquiry: Analysis of Questionnaires from 120 NHS Trusts* in September 2026, Neonatal Services have undertaken a review of the report's findings to assess the level of assurance that can be provided against the themes identified. This review has also sought to identify any areas of vulnerability within the service and to determine whether existing governance, safety and escalation processes are sufficiently robust to mitigate risks highlighted by the Inquiry**.**

This report seeks to highlight the key findings and recommendations of the Thirlwall Inquiry whilst providing a level of assurance that these will be acted upon to ensure babies receiving care from the neonatal services are kept safe by effective governance arrangements, clinical pathways, workforce training, organisational culture, and assurance mechanisms

Introduction

Following the conviction of Lucy Letby and the subsequent establishment of the Thirlwall Inquiry, a questionnaire was issued to all 120 NHS Trusts providing neonatal services in Autumn 2023. The questionnaire sought information across a range of themes, including governance, leadership, organisational culture, management arrangements, and multidisciplinary working relationships. ULTH submitted its mandatory response to the Inquiry in December 2023.

Prior to the release of the questionnaire, Neonatal Services at ULTH had already undertaken an internal review of several themes emerging from the criminal proceedings. This review focused on recruitment and pre-employment checking processes, Freedom to Speak Up arrangements, the service's ability to identify and respond to emerging trends and themes, and benchmarking against national neonatal mortality and morbidity indicators. The purpose of this review was to provide

assurance regarding the effectiveness of existing governance and patient safety arrangements and to identify any opportunities for further improvement.

Following the release of the *Report for the Thirlwall Inquiry: Analysis of Questionnaires from 120 NHS Trusts,* Neonatal Services at ULTH have further reviewed its service offering based on the finding sand recommendations of the Thirlwall Inquiry

Key Findings

The key findings of the Thirlwall Inquiry underscore the critical importance of strong leadership, organisational culture, governance, and safeguarding processes within neonatal services, and the direct impact these have on protecting babies from harm. In relation to the arrangements in place at the Countess of Chester Hospital, the Inquiry found that:

- There was a complete failure to protect babies on the neonatal unit. Safeguarding processes were not initiated when concerns about possible deliberate harm first emerged, and there was a widespread lack of understanding that safeguarding action can and should be taken on the basis of risk and concern, without requiring definitive proof of wrongdoing.
- Leadership, management, and governance arrangements were found to be dysfunctional, with a significant disconnect between senior leaders and frontline clinicians which meant that consultants' concerns were not appropriately acknowledged or acted upon by senior nursing and executive leaders. The Inquiry also identified wider cultural weaknesses, including inadequate support for staff who raised concerns and a tendency for patient safety issues to be overshadowed by employment, reputational, and managerial considerations.
- A number of opportunities to identify and respond to emerging risks were missed. Unexpected deaths and clinical deteriorations were not viewed collectively as a potential pattern, concerning clinical indicators were not acted upon appropriately, and senior leaders were slow to respond to repeated concerns raised by clinicians. The Inquiry concluded that had concerns been escalated and acted upon sooner, some deaths and incidents of harm may have been prevented.

Collectively, the Inquiry highlights the need for NHS organisations to foster cultures in which concerns are listened to, safeguarding responsibilities are clearly understood, and patient safety remains the overriding priority in decision-making at all levels of the organisation.

Recommendations and Responses

The Thirlwall Inquiry made a series of recommendations aimed at strengthening patient safety, safeguarding, accountability and oversight across the NHS. These can be grouped into the following key themes:

Surveillance

- Installation of baby-monitoring systems with live-stream capability in all neonatal cots and incubators, supported through nationally coordinated funding and implementation.
  A National announcement was made by Secretary of State, Yvonne Cooper, to urgently develop plan to introduce live-streaming cameras on England's Neonatal Units.

Work is currently being undertaken at pace to develop plans for all cots and incubators in every neonatal unit to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. This work is being completed in conjunction with places where live-stream monitoring is already used to benefit from their learning in order that a fit-for-purpose approach is available to support neonatal units to implement this. It is recognised that there will be issues pertaining to IG, safeguarding and confidentiality that will need to be considered as part of the wider plan.

- Strengthened controls around insulin storage and access, including restricted and auditable digital access systems to monitor insulin storage areas
  Drug rooms within both Neonatal Units are subject to digital access controls that restrict access to authorised staff members. Video surveillance is not currently in place in either units drug room but a clear request has been made by Duncan Burton (NHSE Chief Nurse) and Sarah-Jane Marsh (NHSE COO) that, until access to insulin requires the provision of biometric data (e.g. via Omnicell type storage device) Trust's should urgently install CCTV cameras that have capacity to store recordings for at least 28 days in neonatal units. These cameras should be focused on storage fridges, cupboards or units and should be installed by 30th November 2026 at the latest. By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT Neonatology Guide to Safe Insulin Use – currently, pharmacy provision within Neonatal services is recognised as being insufficient as per Neonatal GIRFT and BAPM. This is captured on the Neonatal Risk Register as a moderate risk, with risk grading to be reviewed in light of Thirlwall findings and a Business Case has been drafted to increase pharmacy support for neonatal care/

  Discussions have already commenced with pharmacy and estates regarding the installation of CCTV cameras as outlined above to ensure achievement of the action by the deadline. Furthermore, and following discussion at Group Leadership Team on 18th September, a request was made by Prof Karen Dunderdale that safe medicine management extends beyond just insulin and management of medications within neonatal units (i.e. the Thirlwall recommendations are viewed as a Trust wide issue). Discussions have commenced with Kieron Davey (Fire and Security Manager) and Lisa-Marie Moore (Assoc Chief Pharmacist) to install CCTV in drug rooms by the November deadline- assurances received that this can be achieved.

Scrutiny

- Development of interoperable NHS digital systems to support the consistent recording, monitoring and review of neonatal data across organisations
  The Trust currently uses Badgernet, which is a digital platform that allows recording and review of baby's care – the Trust as recently agreed to fund the where the baby receives care and the data is extracted for national audits, such as NNAP. The information is also used to populate monthly quality dashboards by the Neonatal ODN – the contents of these are discussed through local

governance processes – and the organisation receives quarterly neonatal SSQD submission that are reviewed via CEG for assurance

- Strengthened Board-level oversight of deaths involving babies and children, with clear escalation processes for concerning trends, patterns or outliers.
  Deaths involving babies within maternity and neonatal services are currently reported to the Board via MNOG, which includes an overview of PMRT cases that would support identification of any themes. There is a plan to incorporate unexpected baby and child deaths in hospital into CYPOG to provide upward assurance to Board.

  In addition to MNOG and CFYPOG reporting processes, deaths are overseen by the Medical Examiners Office, SUDIC processes and the Child Death Overview Panel thus providing opportunity for the identification of trends in deaths that may initially appear unrelated. For deaths that appear as a cluster, movement in the HSMR (which is reviewed at both Mortality Oversight Group and Clinical Effectiveness Group) combined with feedback from the Neonatal ODN would offer an early opportunity for increased scrutiny – such an event would be reported into Clinical Effectiveness Group, Patient Safety Group, Mortality Oversight Group, CYPOG and/or MNOG, which report upwards to QGC and hence offer a clear escalation path to Board

- Introduction of designated and appropriately trained neonatal data leads to support regular reporting of mortality, safety and quality indicators to Trust Boards.
  The Trust does not currently have a Neonatal Data Lead but does employ a Neonatal Data Clerk to support preparation of reports for governance. Many of the existing mortality, safety and quality indicators pertinent to neonates are provided by the Neonatal ODN Data Analyst – the Trust receives these reports on a monthly basis and attends regular meetings with the Neonatal ODN to discuss performance against KPI's. These monthly reports are shared via PRM, MNOG and local governance processes – the data is derived via Badgernet.

  Plans are in place to add the lack of Neonatal Data Lead to the specialty Risk Register and to better understand what mitigations can be applied in the absence of this role.

Pathways and Processes

- Clarification that Sudden Unexpected Death in Infancy and Childhood (SUDIC) processes apply to babies who die unexpectedly in hospital, supported by revised national guidance and simplified documentation.
  All babies that die in the perinatal period at ULTH currently receive a PMRT or Late Loss review, which is currently accepted in lieu of SUDIC. All deaths (for all children up to 18 years, and regardless of anticipation of and/or location of death) are subject to external scrutiny via the Child Death Overview Panel process, enabling any themes to be identified/escalated as needed.

  A recent request by Duncan Burton and Sarah-Jane Marsh clarifies the expectation that no member of staff should ever assert that they did not know

what to do in response to a sudden and unexplained death. They further clarified that SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units.

As per this expectation, ULTH has urgently communicated to all relevant staff via email that the SUDIC process applies as set out above – this was completed 23rd September in advance of the deadline date of Monday 28th September 2026.This communication reinforces that SUDIC reporting is to run alongside internal reporting processes (Appendix 1)

- Introduction of a National Suspicion of Deliberate Harm protocol to guide the management of concerns that a healthcare worker may have deliberately harmed a patient. The protocol will emphasise immediate action, safeguarding and patient protection, even where concerns have not yet been substantiated.
  As this is a National recommendation, we will await further guidance. Locally, if a staff member were suspected of causing deliberate harm to a baby or child, this would be managed in line with the Allegations Management processes – this would include referral to LADO and internal HR processes which sit within the Disciplinary policy. The children and adult safeguarding team have monthly meetings with HR to discuss allegations of harm against staff – the HR team then provide a high level upward report to SVOG outlining open disciplinary cases and the identification of any themes. A recent example of a cluster of babies having high potassium levels at LCH resulted in immediate investigation, which included reviewing maternal blood results, feeding methods, medication regimes and a roster review to determine if there was a commonality between the cases. The Neonatal ODN were involved throughout for openness and transparency.

- Full implementation of the National Bereavement Care pathway for neonatal deaths across all NHS Trusts.
  The National Bereavement Care pathway is already implemented at ULTH – there is a plan benchmarked to ensure standards are being delivered and plans put in place to mitigate where gaps are identified. A further request has been made by

- Strengthening of the Medical Examiner system through neonatal-specific guidance, enhanced safeguarding prompts, improved specialist support and ongoing system review.
  Currently, any live born baby that dies in a ULTH hospital receives a Late Loss or PMRT review and they are referred to the coroner. These deaths are captured on the Mortality module of Datix and are subject to CESDI grading. All deaths of babies, children and young people under 18 years of age are also reviewed via Child Death Overview Panel, where a multidisciplinary panel scrutinises deaths for avoidability. This would potentially include identifying themes of deliberate harm. However, it should be recognised that the SUDIC

process can take a few months and should be a failsafe to identify trends rather than the first mechanism to highlight concerns

Oversight and Assurance

- Establishment of a national panel of independent clinical experts to support the rapid investigation of significant patient safety concerns and emerging risks.
  Plan is to await further information on what this panel may look like in the future

- Enhanced regulation and scrutiny of healthcare organisations through increased unannounced inspections by the Care Quality Commission (CQC), greater use of practising clinical experts within inspection teams, and a stronger focus on determining whether patients are demonstrably safe rather than simply assessing compliance with processes and policies. In addition, introduction of regular external review of CQC performance through the Health and Social Care Committee.
  Plan is to await further information on what changes to the CQC inspection processes may look like in the future may look like in the future. Within neonatal care, assorted assurance processes are in place to ensure that patients are truly safe – for example, via Matron audits; upward assurance through CEG, IPCG and PSG; adherence with AAR and PSII framework; mortality and morbidity meetings. The Trust is also a pilot site for Martha's Rule, which offers patient's, patient's representatives and staff to raise concerns regarding deterioration if they feel their concerns are not being heard, and has Freedom to Speak Up processes.

- Greater accountability for NHS managers, including strengthened fit-and-proper-person requirements, a proposed barring framework and an individual duty of candour.
  All ULTH employees, including those in managerial positions, are subject to DBS check (with a risk assessment undertaken if there is a disclosure as escalation to DBS panel where appropriate), a model declaration form, qualification and professional registration checks, references etc in line with NHS Employer Standards. Staff involved in recruitment are required to complete recruitment and selection training to optimise safe recruitment and staff in director level positions are required to undergo a fit and proper persons check. Managers that are found to not be performing to the required standard are subject to HR performance management processes with those unfit to retain their role being subject to dismissal in line with legal requirements.

Training and Workforce

- Mandatory safeguarding training for all staff, Board members and Non-Executive Directors, including specific training on recognising and responding to concerns about deliberate harm
  All Trust staff, including Board members and NED's, are expected to complete Safeguarding training at the collegiate level and frequency appropriate to their role – compliance with this training is monitored via governance processes. Local training includes all categories of abuse and identifies that anyone – including staff members – can perpetrate harm. Adult safeguarding training

includes a section relating to People in Positions of Power and Trust and how this relates to their employment whereas child safeguarding includes information about allegations against staff members and LADO processes.

The request made by Duncan Burton and Sarah-Jane Marsh is that all Trusts should ensure that all staff (including Board members) are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Furthermore, there is an expectation that Boards will assure themselves that the safeguarding of babies and children is given the level of prominence required to ensure safety.

ULTH Safeguarding team are assured that their training offering meets this recommendation and that the content relating to allegations against staff (covering both their personal and professional lives) is regularly reviewed in line with local and National processes (i.e. the Lincolnshire Safeguarding Children Partnership has a LADO process upon which the ULTH process is based)

- Expansion of the paediatric and perinatal pathology workforce through increased training opportunities and sustained investment to address national workforce shortages.
  Plan is to await further information on what these changes may look like in the future.

Collectively, these recommendations seek to strengthen safeguarding, improve the early identification and escalation of patient safety concerns, enhance organisational accountability, and ensure that the safety of babies and children remains the primary consideration in decision-making at every level of the NHS.

Next steps

Following publication of the Thirlwall Inquiry report, it is important that ULTH considers the findings and recommendations in the context of its own services and governance arrangements. Whilst a number of the recommendations require a nationally coordinated response from organisations such as NHS England, the Department of Health and Social Care and the CQC, several can be progressed locally to provide assurance that patient safety remains the Trust's highest priority.

Specifically, there are opportunities for ULTH to undertake a local review of its neonatal governance arrangements, safeguarding processes, mortality surveillance, escalation pathways, speaking-up culture, Board assurance mechanisms and staff training programmes. Consideration should also be given to the adequacy of local systems for recognising, reporting and responding to patient safety concerns, including concerns relating to potential deliberate harm. This will allow the Trust to identify areas of good practice, determine whether any improvement actions are required, and provide assurance to the Board that effective systems are in place to protect babies and children from harm. Benchmarking against the recommendations is being overseen by the Trusts Compliance Team

Conclusion

The Thirlwall Inquiry, alongside a number of recent national inquiries and reviews, reinforces the responsibility of NHS organisations to maintain robust systems that protect patients from harm and ensure that patient safety remains the overriding priority. The inquiry highlights the importance of strong leadership, effective governance, a positive speaking-up culture, and clear safeguarding processes in identifying and responding to emerging risks.

By reviewing and addressing any gaps in governance arrangements, clinical pathways, workforce training, organisational culture, and assurance mechanisms, ULTH has an opportunity to strengthen their safety systems and drive continuous improvements. Whilst many of the arrangements highlighted by the Inquiry are already established within Trust, the report provides an opportunity to review their effectiveness and identify opportunities for further enhancement. For example, the Trust benefits from established governance and safeguarding frameworks and maintains a strong working relationship with the Neonatal Operational Delivery Network, which supports the identification of service gaps, emerging risks, safety concerns and trends that may impact on the quality and safety of neonatal care.

However, the presence of processes alone is insufficient and organisations must be assured that those processes are consistently understood, enacted and capable of identifying concerns at the earliest opportunity. Accordingly, the recommendations provide an opportunity for ULTH to further strengthen its arrangements relating to governance, oversight, data surveillance, escalation pathways, safeguarding practice, workforce development and Board assurance processes. By identifying areas of good practice, recognising and addressing gaps, and providing assurance that effective systems are in place to protect babies from harm, ULTH will continue to embed a culture in which patient safety is prioritised.

Appendix 1 – SUDIC Communication sent via email

Sent on behalf of Amol Chingale, Ruchika Gupta and Kate Rivett

Many of you will have read the recommendations arising from the Report for the Thirlwall Inquiry: Analysis of Questionnaires from 120 NHS Trusts, published following the investigation into the circumstances surrounding the conviction of Lucy Letby, a former neonatal nurse at the Countess of Chester Hospital, for the murder of seven babies and the attempted murder of seven others.

The report sets out fourteen recommendations aimed at strengthening patient safety within neonatal services and reducing the risk of similar incidents occurring in the future. One of these recommendations calls for greater clarity regarding the application of Sudden Unexpected Death in Infancy and Childhood (SUDIC) processes to babies who die unexpectedly in hospital. The recommendation proposes that this clarification should be supported through revised national guidance and simplified documentation.

At present, babies who are born alive but die during the neonatal period are typically subject to a Late Loss Review or review through the Perinatal Mortality Review Tool (PMRT) and only rarely are such deaths considered through the SUDIC process. The SUDIC protocol applies to every death, or collapse leading to death, of an infant or child under 18 years of age that would not reasonably have been expected 24 hours earlier and where no apparent pre-existing medical cause of death has been identified, regardless of the location of death. In line with the Thirlwall Inquiry recommendations, this definition must now be understood to include sudden and unexpected deaths occurring within neonatal units.

The implementation of this recommendation will require neonatal, paediatric, maternity, safeguarding, bereavement, and governance teams to review local processes to ensure that all sudden and unexpected neonatal deaths are considered against SUDIC criteria and managed in accordance with emerging national guidance. Clinical teams should ensure that cases are escalated appropriately, that early multi-agency discussions take place where indicated, and that parents and families receive clear, compassionate communication throughout the review and investigation process. Existing pathways for Late Loss Review and PMRT should be reviewed alongside SUDIC requirements to ensure alignment, avoid duplication, and maintain a robust approach to organisational learning and patient safety. Current Group guidance on the SUDIC process can be accessed here >> https://nhs.sharepoint.com/sites/RWD_CorporateGovernance/_layouts/15/viewer.aspx?sourcedoc={3d315e07-f933-49b0-ab8d-90698195915b}

With immediate effect, please could all staff note these requirements and ensure that escalation and reporting pathways followed – the SUDIC process forms part of safeguarding training and hence staff should be familiar with the requirements. By strengthening these processes, we can support greater transparency, learning, and

assurance, while continuing our commitment to delivering safe, high-quality, person-centred care for babies and their families

NHS
Lincolnshire Community and Hospitals NHS Group

Finance Briefing M6

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*8.3*
Report title	*Finance Briefing M6*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• Information
Accountable Director	*Paul Antunes Goncalves* *Group Chief Financial Officer*
Author(s)	*Finance Team*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*Content discussed at Finance and Performance Committee*
Financial implications, if applicable	*None*
Action / decision required	*The Board is asked to:* • *Note the contents of the Finance report in respect of Revenue, Capital, Cash and CIP positions.* • *Note the three key areas of internal focus – delivery of our variable income, delivery of our efficiency target and workforce controls (bank and agency).* • *Note the submission a recovery plan to the regulator, outlining path to balanced financial position.*

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 Board is asked to note the following:

- 2026/27 Revenue position M6 YTD (Year to date)

The Group reported a year-to-date deficit of £15.2m at Month 6, representing an adverse variance of £7.7m against plan. The Group have submitted a recovery plan to the regulator in line with request, this plan outlines the path back to plan. Delivery of the plan remains dependent on recovery in activity performance, achievement of the efficiency programme, and continued workforce controls.

- 2026/27 Capital position M6 YTD

The Group delivered capital expenditure of £24.4m (£22.4m lower than plan).

- 2026/27 CIP position M6 YTD

The Group delivered savings of £36.4m (£5.8m lower than plan).

- M6 Cash position

The Group ended the month with a cash balance of £31.9m (£1.5m higher than plan).

Lincolnshire Community and Hospitals NHS Group
Trust Board – 3 November 2026
Finance Briefing M6

Executive Summary

The Group reported a £15.2m year-to-date deficit at Month 6, which is £7.7m adverse to plan. The Group first went off plan at month 5 due to shortfalls in our variable activity, under delivery of our efficiency programme and increased costs on our temporary workforce. As a result of the adverse movement in month 5, the Group were formally requested to submit a recovery plan to the regional regulator team. This recovery plan was approved by Group Leadership Team and Trust Board and submitted on 4 October.

The recovery plan outlines the path back to plan which focuses on our key variance issues and additional internal and external actions to get us back to our breakeven plan. The adverse variance is within ULTH position, so the plan is focused on the acute side of the Group but where actions can drive an improved performance, these will be enacted across the Group.

Activity volumes delivered by the Group are £5.3m below plan, this is driven by below planned levels of outpatient activity and non-achievement of our repatriation income target. The Trust are working on our activity recovery plan led by our Chief Operating Officer and discussion are ongoing with our commissioning colleague. In agreement with our commissioner the Group have assumed income at planned level for month 6 whilst recovery plan is enacted.

Our activity recovery plan will focus on delivering the activity required to ensure patient waits are reduced, key operational targets are achieved or exceeded alongside support the Group financial position. Key areas of focus include maximising activity through our elective hubs and improvements on our outpatient's delivery particularly first appointments.

Our efficiency programme has seen a step up in delivery requirement in quarter 2, however some of our transformational efficiency schemes are delayed resulting in a variance from plan, at month 6 this totalled £5.8m. The Group also have a shortfall of schemes against our annual requirement, this has been driven by reduce scope on delivery, delays in schemes and a planning gap. Works continues mitigating our gap. Deep dive sessions have been completed with our care groups and corporate leads which have identified further opportunities that are being developed. This is a key element of our recovery plan that is being led by our Deputy Chief Executive.

The workforce position had started the year strongly, building on the good work during 2025/26, month 1 and month 2 had seen reductions in overall WTE however in month's 3-5 there has been an increase particularly within bank. Month 6this position has stabilised and there has been a small reduction. The increase in temporary working has been driven by increased sickness and continued use of escalation capacity across our emergency pathway. Our Chief People Officer is working with our Care Groups to ensure the trajectory is recovered and mitigation plans are developed.

These three key areas are our 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.

Our capital spend is behind our planned level, the shortfall is principally within the Boston CDC Project but in part due to timings of works valuations ahead of month end close. To ensure best value for money, the Group have approved an overcommitment on the capital plan of up to £5m, this will be monitored and managed by the CFO and Estates Director to ensure the Group remains within our capital limit for the year. A revised capital forecast has been produced and will be monitored on a monthly basis to ensure all funds are utilised by the end of the year.

Our cash balance is in line with our plan position, with a closing balance of £31.9m at the end of Month 6. Cash continues to be monitored on a weekly basis and is reported to Finance and Performance Committee on a monthly basis.

Summary Position

Month 6 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)	1.3	(2.1)	(3.4)	0.0	0.1	0.0	1.3	(2.2)	(3.4)
CIP Delivery	7.7	6.3	(1.4)	0.7	0.7	(0.1)	6.9	5.7	(1.3)
Capital Spend	8.2	4.9	(3.2)	0.7	0.0	(0.7)	7.4	4.9	(2.5)
Agency Spend	(0.7)	(1.5)	(0.8)	(0.0)	(0.0)	0.0	(0.7)	(1.5)	(0.8)
Cash Balance	(7.3)	(8.9)	(1.6)	(0.6)	3.3	3.9	(6.7)	(12.2)	(5.5)

Month 6 Position	Group performance			LCHS performance			ULTH performance		
	Year to Date			Year to Date			Year to Date		
	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m	Plan £m	Actual £m	Var. £m
Surplus / (Deficit)	(7.5)	(15.2)	(7.7)	(0.4)	(0.2)	0.2	(7.1)	(15.0)	(7.9)
CIP Delivery	42.2	36.4	(5.8)	4.4	4.0	(0.5)	37.7	32.4	(5.3)
Capital Spend	46.7	24.4	(22.4)	2.3	0.3	(1.9)	44.5	24.1	(20.4)
Agency Spend	(5.2)	(8.1)	(2.9)	(0.3)	(0.2)	0.1	(4.9)	(7.9)	(3.0)
Cash Balance	30.5	31.9	1.5	26.2	12.8	(13.4)	4.3	19.1	14.9

Revenue Position

The Group's year to date financial position is a £15.2m deficit at Month 6, which is £7.7m adverse to plan. The Group went off plan in month 5 due to our activity volumes being lower than plan, our efficiency programme delivery not stepping up in quarter 2 and pressures on our temporary workforce linked to increased sickness and escalation capacity. These issues were identified as pressures in quarter 1 and work continues to mitigate them.

Key actions

Activity recovery plan, our Chief Operating Officer has developed a recovery plan to address our activity shortfall, initial focus has been on our 6 highest services that are off plan for outpatients. Further work is ongoing to maximise our elective capacity through our hubs. This will reduce our waiting list position, support delivery of our operational performance standards and improve our financial position.

Efficiency programme, our Deputy Chief Executive has chaired (with our Chief Executive also in attendance) deep dive sessions with our Care Groups and Corporate leads to review

our efficiency delivery and to support the generation of additional ideas. External benchmarking, learning from other providers alongside internally generated ideas were discussed. A key focus was on the reduction of our cost base and focusing on productivity improvements. All actions and schemes are captured in our efficiency monitoring system with any ideas that can't be delivered in 26/27 becoming pipeline schemes for future years.

Temporary workforce control, our Chief People Officer is leading the development of workforce trajectories with our services to ensure our workforce reduction plan is delivered. This is being supported by our Chief Medical Officer and our Chief Nurse who each lead on elements of our workforce. Centrally, there is a key workstream on reducing sickness and absence as there has been an increase during 26/27.

Additional action, the Chief Financial Officer, has reviewed recovery actions from other organisations to ensure that all options for additional control have been implemented, in additional discussions are ongoing with our commissioners regarding derisking our financial position.

Capital Position

Our capital spend is behind our planned level, the shortfall is principally within the Boston CDC Project but in part due to timings of works valuations ahead of month end close, with the process being reviewed and improved. To ensure best value for money, the Group have approved an overcommitment on the capital plan of up to £5m, this will be monitored and managed by the CFO and Estates Director to ensure the Group remains within our capital limit for the year. A revised trajectory of spend has been developed and shared with Finance and Performance Committee to provide assurance on expenditure across the remainder of the year.

The Group have engaged with the system on reforecasting our capital expenditure and are committed to fully delivering our spend in year. This includes developing mitigation in case of scheme slippage.

Summary of Principal Financial Risks

Risk	Current Position (M6)	Mitigation
Activity shortfall	£5.3m below plan	COO recovery plan and elective productivity actions
CIP delivery	£5.8m adverse variance	Deep-dives and enhanced PMO oversight
Workforce growth	Temporary staffing increasing in M3 – M5 (M6 stable)	Enhanced workforce controls and recruitment review
Capital delivery	£22.4m below plan	Monthly trajectory reviews and programme monitoring

Other Items

As part of the national exercise on deconstructing the block, the Group have engaged with system partners to ensure the community application of the guidance has been applied consistently. Our return has been submitted, and we will continue to work collaboratively with our ICS colleagues. In addition, the acute analysis has been refreshed to inform the 27/28 contract.

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	*03 November 2026*
Agenda item number	*8.4*

Finance and Performance Committee Upward Report of the meeting held on 25 September 2026

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	
1b: Reduce waiting times for our patients	*X*
1c: Improve productivity and deliver financial sustainability	*X*
1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	

3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	Finance and Performance Committee
Report from meeting held on:	25 September 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 25 September 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 1b:

a) Committee Performance Dashboard
b) Operational Performance Report
c) NHS Oversight Framework (NOF) Quarterly Report

The Committee received the August 2026 performance dashboard with **reasonable assurance** and noted that there was a mixed position across the Group, with several key indicators showing further deterioration compared to July 2026.

The most notable deteriorated indicators were related to financial performance, diagnostics, cancer recovery, community data quality and patient flow metrics. Other indicators related to acute, urgent and emergency services remained under pressure, while performance across core front door measures remained relatively stable.

The Committee was informed that recovery actions across finance, diagnostics, cancer pathways and patient flow would require sustained executive oversight during the remainder of the 2026/27 financial year.

The Committee received the Operational Performance Report which included the Out of Hospital Care Oversight Group, Unscheduled Care Oversight Group and Planned Care Oversight Group Upward Reports.

The Out of Hospital Care Oversight Group Upward Report noted the strong and sustained improved performance against the community metrics notably the continued improvement across the community waiting lists. The report also noted the actions being implemented to progress the flow transformation programmes.

The Unscheduled Care Oversight Group Upward Report highlighted the continuing strong Emergency Department performance, which reflected consistent delivery above 80% since April 2026. The report also noted that the technical phase of the Electronic Patient Record (EPR) programme had been completed successfully. The Committee noted that actions continued to be undertaken to improve the position in relation to staff training compliance so operational go live can go ahead in October 2026.

The Planned Care Oversight Group Upward Report informed the Committee that at the end of July 2026 that all 3 cancer standards were below plan. The report informed the Committee that the total waiting list delivered higher than plan for July 2026 but was an improvement on the position in June 2026.

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

The Committee reviewed the National Oversight Framework (NOF), the methodology and framework of which had been updated for 2026/27 to introduce new measures and a simplified accountability approach.

Assurances in respect of Objective 1c:

a) Finance Report including CIP, Capital, CRIG and Productivity, Improvement and Transformation Oversight Forum (PITOF) upward report
b) Quarterly Procurement Update – September 2026

The month 5 Finance Report was received with **reasonable assurance** that the Group YTD had delivered an £13.1m deficit which was £4.3m higher than the planned deficit. The Committee was updated on the actions being implemented to mitigate, and where possible, recover the Group's deficit position. The Committee was also updated on the work to develop a financial recovery plan for presentation to NHS England at the end of September 2026.

The Committee noted that the Cost Improvement Programme (CIP) and capital expenditure were behind plan. The report also stated that the Group's cash position continued to be challenging, due to the impact of the revenue cash position. The Committee also noted that the cash position was being reviewed on a weekly basis by the Cash Oversight Group to determine whether corrective actions were needed.

The Capital, Revenue and Investment Group (CRIG) report for August 2026 was received for information. The Committee also noted the items reviewed

by CRIG in April to July 2025 and subsequently approved by the Group Leadership Team.

The PITOF report was received by the Committee noting the contents of the report and the escalations made.

The Committee received a report which provided a quarterly update on the procurement activity in the Group.

The Committee was substantially **assured** by the quarterly Procurement Update.

Assurances in respect of Objective 1d:

a) Estates & Facilities Update
b) Substation Lessons Learned

The Committee received, with **reasonable assurance**, an Estates and Facilities update which acknowledged the positive progress made against compliance improvement programmes and supported the continued delivery of recovery actions aimed at strengthening assurance, operational resilience and statutory compliance across the Group.

The Committee was **reasonably assured** by a 'lessons learnt' report into the review into the Substations 1 and 3 Projects. The review had provided a valuable opportunity to assess capital project governance arrangements and identify improvements to support future delivery. The report assured the Committee that future projects would follow a more rigorously, collectively challenged approach ensuring project compliance and delivery. The Committee was informed that, henceforth, the Group would work with preferred contractors to design the project structure and outline so they can proceed with construction without the possibility of cost increments or project redesign.

Assurances in respect of other areas:

a) Board Assurance Framework 2026/27
b) Risk Register
c) Information Governance Group (IGG) Upward Report to include a focus on FOIs and SARs
d) Update on the Orthodontics Service

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

The Committee received and was **reasonably assured** by the IGG Upward Report.

The Committee also received and reviewed a report which updated on the establishment and progress of improvement actions to performance in relation to Subject Access Requests (SARs) and Freedom of Information (FOI)

requests. The report provided contrasting levels of assurance across the two areas.

The Committee noted that, for SARs performance, the trajectory was projected to ensure that it returns to a compliant position with no backlog cases by the end of March 2027. The report provided the Committee with **limited assurance** regarding the organisation's ability to deliver sustained compliance within required timescales. The report stated that progress against the monthly improvement trajectory, backlog reduction and the impact of additional capacity would continue to be closely monitored, with any material variance from trajectory escalated through the established performance governance arrangements.

The Committee noted that, for FOI performance, Quarter 1 2026/27 compliance exceeded the agreed monthly improvement trajectory for the first time. The improvement reflected focused management attention, additional capacity and changes to operational arrangements. The report provided the Committee with **increased assurance** that there had been a significant improvement in FOI performance, though this remained contingent on the organisation demonstrating that the improvement could be sustained.

The Committee was informed of the developments around the Group's fragile Orthodontics Service, with the resignation of its two remaining consultants. The Group was in discussions with the ICB about next steps. The Committee would be updated on the developments on those discussions.

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 no changes are proposed.

6.0 Group Board Action Required

6.1 The Group Board is asked to:

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

Dani Cecchini, Non-Executive Director
24 September 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 November 2026*
Agenda item number	

Finance and Performance Committee Upward Report of the meeting held on 22 October 2026

Accountable Director	*Paul Anutunes-Goncalves, Group Chief Finance Officer*
Presented by	*Ian Orrell, Associate Non-Executive Director*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Committee 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 whilst addressing our requirements for sustainability and our Green agenda	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	

3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Board Committee Upward Report to the Group Board

Report for meeting of the Board to be held on:	03 November 2026
Report from:	Finance and Performance Committee
Report from meeting held on:	22 October 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 22 October 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 1b:

a) Committee Performance Dashboard
b) Operational Performance
c) UTC Performance Deep Dive
d) PRM Upward Report

The performance dashboard offered **reasonable assurance** with the Committee noting continued pressure in elective recovery, cancer, diagnostics, discharge and community length of stay with dashboard alerts being addressed through reports.

The Committee received the Out of Hospital Care Oversight Group, Urgent and Emergency Care Oversight Group and Planned Care Board Upward Reports noting the contents of each. The Committee was pleased to note the continued progress in respect of attendance and admission avoidance with patients diverted through Urgent Community Response (UCR), resulting in 2.5k avoided admissions for long term conditions. Despite admission avoidance there continued to be challenges noted in respect of flow and patients with no criteria to reside (NCTR).

Urgent and emergency care 4-hour performance remained above plan, despite the increased attendance with 12-hour performance remaining the main challenge. Cancer performance continued to be off plan however improvements were noted in the 31-day standard with capacity issues resolved in breast and recovery of skin continued. 62-day performance

remained challenging in the diagnostic pathways for cancer with the Committee noting that plans were in place with recovery trajectories to be presented to the Committee in November for all tumour sites.

Elective performance was achieving a positive position with the expectation of delivery for the first half of the year. The waiting list remained challenging alongside an increase in referrals. DM01 continued to be challenges with focused recovery on MRI, audiology, ultrasound and echocardiogram. Recovery plans were being supported by the Integrated Care Board (ICB) with an expectation of 80% performance achievement by the end of the year.

The Urgent Treatment Centre deep dive was received with **reasonable assurance** with performance achieving of close to the local stretch target of 98%, with Lincoln County Hospital remaining the challenged location. This was noted to be due to change in streaming, reduced clinic-room capacity and delays in cross organisational referrals. The Committee noted the challenges associated with cultural change and determined the need for a referral to the People Committee to determine how these barriers could be removed to achieve benefits of the move to single organisation, particularly in respect of sub-specialty referral challenges.

The Performance Review Meeting (PRM) upward report was received with **substantial assurance** with the Committee noting the position.

Assurances in respect of Objective 1c:

a) Finance Report including CIP, Capital, CRIG and Productivity, Improvement and Transformation Oversight Forum (PITOF) upward report
b) Better Care Better Flow update

The Finance Report was received with **reasonable assurance** with the month 6 position reported as a £15.2m deficit against plan, an adverse variance of £7.7m. LCHS was noted to be ahead of plan with the forecast to deliver the breakeven plan. The drivers behind the position were noted to be activity shortfall, delayed delivery of Cost Improvement Programmes (CIP) and temporary staff pay expenditure.

Discussions were taking place with the ICB in respect of activity recovery with consideration of blocking the contract at contract value to support activity, and this was reflected in the Month 6 position. Star chambers had taken place during October to gain grip and control on the CIP position, including determining delays, mitigations within the care group and factors to address delays in material programmes.

Pay pressures were noted, particularly in respect of overspend in ED and escalation areas to support operational pressures. The Committee noted the overspend in medical staffing with a variety of workstreams being reviewed through the star chambers.

Capital spend was noted to remain behind plan however mitigations were in place, including over-commitment. The Committee received the recovery plan, noting the focused areas including CIP, temporary staffing and activity recovery with multiple workstreams associated with each area.

The Capital, Revenue and Investment Group Upward report was received and noted by the Committee.

The PITOF upward report was received with areas of concern noted to be the Better Care Better Flow programme and medical workforce programme. Monday.com was noted to be maturing supporting oversight and developing wider benefits mapping.

The Better Care Better Flow Update was offered to the Committee providing a detailed update on the progress to date. It was noted that the programme had commenced on the 1 September with early results showing a 20% increase in flow and an 18% increase in discharge. The programme of work was noted to require a £3.5m saving which had been impacted by the later commencement date however there was recognition of the ability to achieve the recurrent cost saving by the end of March 2027, impacting 2027/28.

The Committee noted the discussions that had taken place in the executive space regarding the approach following the delayed implementation. The Committee supported the decision not to remove beds during the peak-winter period so as not to compromise safety or performance. The expectation remained for the removal of 56 beds recurrently however it was noted that the timing of the removals would be confirmed. The pilot of the initial 3 wards was noted as positive with the intention for this to be rolled out to a further 11 wards.

Assurances in respect of Objective 1d:

a) PPM Recovery Programme Report
b) Premises Assurance Model (PAM) Annual Self-Assessment
c) Sustainability and Green Strategic Plan (including Net Zero)

Reasonable assurance was offered through the Planned Preventative Maintenance (PPM) Recovery Programme report with the Committee noting the 263 recommendations made across the 4 workstreams. Asset surveys were underway Pilgrim and Grantham hospitals, due to conclude by January 2027, with the Lincoln survey having been completed. The work to procure a new CAFM (computer-aided facility management) system was progressing well which would support the teams to progress the recommendations.

The PAM annual self-assessment report provided **reasonable assurance** however due to changes in the scoring methodology it was noted that it was not possible to compare directly to the previous year results. A number of additional questions were included, with focus on premises protection under Martyn's Law and helipad governance.

Monthly monitoring of actions plans was in place, and updates would be offered to the Committee on a quarterly basis with low scores noted to be in relation to the additional questions which would be addressed through the actions in place.

The upward report from the Green Group provided and update on the progress of the sustainability and Green Strategic Plan with significant work undertaken on the climate change risk assessment. Completion of the carbon baseline would help the Group to track and monitor progress of the green plan with risks noted to be associated with extreme heat and flooding, capital prioritisation and ageing estate.

Assurances in respect of other areas:

a) Board Assurance Framework 2026/27
b) Risk Register
c) Policy Position
d) Cyber Compliance Report

The Committee received the Board Assurance Framework noting there were no proposed changes to the risk and assurance ratings and the narrative updates that had been provided. Committee members requested more detailed updates in respect of actions to provide clarity on progress.

The risk register was received by the Committee with the position noted, including an increase in 1 high risk following realignment from the Quality Committee. The risks overseen by other Committees were noted with Committee members noting that these were being considered in the appropriate manner by the Committee.

The policy position report was received with **reasonable assurance** with progress being noted in respect of documents being assigned to care groups and the archiving of obsolete/superseded documents. The compliance for corporate documents was noted alongside the work to identify documents that could be developed ahead of single entity on 1 April 2027.

Reasonable assurance was received through the cyber compliance report with the Committee noting the improvement in the overall IT health risk score. The efforts of the team were noted following the positive Go Live for the Electronic Patient Record on the 13 October 2026 and work was required to develop the narrative within the Board Assurance Framework to reflect the positive progress.

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) People Committee: cultural and workforce barriers affecting cross-organisational specialty referrals, particularly within urgent treatment centre pathways and in preparation for the single organisation.

4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

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
- note the referral to the People Committee

Ian Orrell, Associate Non-Executive Director
22 October 2026

NHS
Lincolnshire Community and Hospitals NHS Group

Group Estates Long Term Delivery Plan - 2026

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*8.5*
Report title	*Group Estates Operational Delivery Plan*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Approval*
Accountable Director	*Michael Parkhill, Group Chief Estates and Facilities Officer*
Author(s)	*Alistair Nelson*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial*
Prior approval process, if applicable	*First report*
Financial implications, if applicable	*[insert details of any financial implications arising from the proposals within the report]*
Action / decision required	*The Board is asked to:* • Approve the Group Estates Operational Delivery Plan

Assurance Rating Key:

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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high-quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	*x*
1b: Reduce waiting times for our patients	*x*
1c: Improve productivity and deliver financial sustainability	
1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our green agenda	*x*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
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 (i): Enhance our digital capability through innovation delivering the 10-year health plan	*x*
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	*x*
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	*x*

Executive Summary

Executive Summary

The LCHG Estates Long Term Delivery Plan 2026-2036 sets out a ten-year programme to modernise, optimise and transform the Group's estate in support of high-quality, sustainable healthcare across Lincolnshire. The plan translates clinical transformation and Group priorities into estate delivery, aligning investment with the NHS 10-Year Plan, Integrated Care System priorities and the ambition to deliver more care closer to home.

The Group Estates Long Term Delivery Plan was developed through engagement at all levels, including workshops on Community and Left Shift, sessions with enabling departments including Digital and Procurement, acute hospital operational teams, patient representatives and external partners within the Lincolnshire health system, and two Trust Board development sessions.

The plan recognises that, despite significant capital investment and estate improvements in recent years, major delivery challenges remain. These include ageing infrastructure, approximately £137.4m of backlog maintenance, fragmented estate ownership, inefficient utilisation of some facilities and significant travel burdens for patients across a large rural county.

The proposed response is a managed transformation programme focused on:

1. Delivering the "Left Shift" of care into communities.
2. Developing neighbourhood care models.
3. Modernising acute hospital infrastructure.
4. Rationalising underutilised estate.
5. Improving clinical adjacencies and patient flow.
6. Supporting digital transformation and AI-enabled working.
7. Reducing backlog maintenance and carbon emissions.
8. Creating a sustainable and resilient estate for future generations.

Strategic Context

The Group serves approximately 799,500 residents across one of England's largest and most rural counties, employing approximately 14,000 staff across three acute hospitals, five community hospitals, CDCs and a wide community estate portfolio.

Key strategic drivers include:

1. Ageing population and increasing healthcare demand.
2. Health inequalities in coastal and rural communities.
3. Poor transport connectivity and accessibility.
4. National requirement to move care closer to home.
5. Requirement to reduce estate backlog and improve sustainability.
6. Integration across community, acute, primary care and system partners.

Strategic Alignment

The covering paper identifies clear alignment with the LCHG strategic objectives, including patient safety and experience, waiting times, modern fit-for-purpose care settings, clinical-pathway transformation and estate rationalisation, prevention and health inequalities, digital innovation, research and innovation, and neighbourhood partnership working.

Theme	Estates Long Term Delivery Plan response
Patients	Modern, safe and accessible settings; improved flow and clinical adjacencies; more care closer to home.
Population	Community and neighbourhood provision, reduced travel, prevention and action on rural/coastal access inequalities.
Productivity and finance	Better utilisation, rationalisation, targeted capital investment and benchmarking-led efficiency opportunities.
Digital	Consistent, resilient infrastructure supporting mobile, remote, hybrid and digitally enabled care.

Sustainability	Energy efficiency, decarbonisation, travel reduction and climate resilience.

Operational delivery priorities and programmes

Area	Delivery priorities
Lincoln County Hospital	Pilot integrated acute care model/acute floor; improve adjacencies; strengthen renal provision and theatre compliance; release appropriate non-clinical space.
Pilgrim Hospital	Develop same-day and ambulatory pathways; improve adjacencies; support maternity, infrastructure, access and resilience.
Grantham & District Hospital	Develop the elective and rehabilitation hub role, supporting planned-care growth and specialist programmes.
Community and neighbourhood	Optimise community assets, develop flexible multi-agency provision, expand local care models and explore mobile provision.
NHSPS estate	Explore transfer of strategically relevant assets through due diligence and formal business cases.
Cross-site	Maternity, theatres, digital enablement, flow, backlog, critical infrastructure and sustainability.

Principle risks and assurance

Risk	Potential impact	Strategic response / assurance
Backlog, compliance and ageing infrastructure	Safety, compliance, resilience and service continuity	Risk-based investment, audits, monitoring, costed actions and escalation through risk/assurance arrangements.
Capital constraints	Delay or rephasing of transformation	Phasing, prioritisation, business cases and use of available core/targeted funding.
Demand and ageing population	Capacity pressure	Care closer to home, flow transformation and estate aligned to future service models.
Rural geography and transport	Access inequalities	Neighbourhood/community delivery, diagnostics, partnerships and digital/mobile options.
Fragmented estate and ownership	Inefficiency and reduced flexibility	Rationalisation, shared use and NHSPS transfer due diligence.
Climate and energy	Cost, carbon and service-resilience impacts	Green Plan alignment, decarbonisation, monitoring and climate adaptation.

Key Findings

Estate Portfolio

The Group currently manages approximately 187,160m² of estate with a total asset value of approximately £286.8m. Total backlog maintenance liabilities exceed £137m.

Key Challenges

The following key challenges have been identified

1. Significant backlog maintenance and compliance pressures.
2. Ageing infrastructure across several acute and community sites.
3. Fragmented ownership structures.
4. Acute site overcrowding alongside underutilised space elsewhere.
5. High energy consumption on acute sites.
6. Large travel distances for patients and staff.
7. Digital exclusion in rural communities
8. Current Strengths
9. Successful capital delivery track record.

10. Modern Community Diagnostic Centres.
11. Strong governance arrangements.
12. Integrated Group model.
13. Established sustainability programmes.
14. Strong alignment with system priorities.

Strategic Benefits

1. **Improved Patient Access and Experience**
The plan supports expansion of community-based diagnostics, outpatient services and neighbourhood care facilities, bringing services closer to where patients live. Delivery is intended to improve access for rural and deprived communities and reduce reliance on travel to acute hospitals.

Benefits
- Reduced travel burden for patients.
- Improved access for rural and coastal communities.
- Quicker access to diagnostics and outpatient care.
- Better patient experience and satisfaction.
- Reduced health inequalities.

2. **Improved Acute Hospital Performance**
Acute site redesign will improve patient flow, clinical adjacencies and operational efficiency across Lincoln, Boston and Grantham.

Benefits
- Reduced delays and bottlenecks.
- Improved emergency and elective pathways.
- Better patient flow and discharge performance.
- Increased resilience during periods of peak demand.
- Enhanced staff productivity.

3. Financial Sustainability

Estate rationalisation, improved utilisation and reduction of duplicated accommodation offer significant opportunities to reduce operational costs and improve value for money. Benchmarking identifies opportunities for efficiency savings in maintenance, utilities and waste management.

Benefits
- Lower revenue costs.
- Improved estate utilisation.
- Reduced energy and maintenance expenditure.
- Better return on capital investment.
- Long-term affordability.

4. Workforce Benefits
Modern working environments, improved digital infrastructure and agile working arrangements support staff wellbeing, recruitment and retention.

Benefits
- Improved staff experience.
- Enhanced workforce productivity.
- More flexible ways of working.
- Better access to collaborative workspace.
- Improved recruitment and retention.

5. Sustainability and Net Zero
The Estates Operational Delivery Plan directly supports the Group Green Plan and NHS Net Zero ambitions through energy efficiency projects, renewable technologies and travel reduction.

Benefits

- Reduced carbon emissions.
- Lower energy consumption.
- Improved climate resilience.
- Reduced patient and staff travel emissions.
- Long-term environmental sustainability.

6.System Integration

The plan supports closer working with Primary Care Networks, local authorities, the One Public Estate programme and neighbourhood teams.

Benefits

- Better integrated care.
- Shared use of public assets.
- Reduced duplication.
- Enhanced system productivity.
- Improved population health outcomes.

Principal Risks

The principal delivery risks were identified through stakeholder workshops. The Board is requested to note these risks, summarised below.
The following risks are highlighted within the Estates Operational Delivery Plan:

Risk	Impact
Backlog maintenance (£137m+)	Safety, compliance and operational resilience
Ageing infrastructure	Service disruption and increased maintenance costs
Capital funding constraints	Delays to transformation programmes
Growing demand and ageing population	Capacity pressures
Rural geography and transport limitations	Access inequalities
Climate and sustainability risks	Future service resilience

Equality, quality, workforce and sustainability implications

Equality and access: the plan is explicitly shaped by rural/coastal geography, deprivation, transport barriers and digital exclusion, with neighbourhood and community delivery intended to improve access and reduce health inequalities.

Quality and safety: estate modernisation, compliance improvement, critical-infrastructure investment and better clinical adjacencies support safer and more resilient care environments.

Workforce: modern environments, digital infrastructure and agile working are identified as enablers of staff experience, productivity and flexible working. Proposed workforce benefits require baselining as part of the benefits plan.

Sustainability: the plan aligns with Group Green Plans and states Net Zero ambitions of 2040 for directly controlled emissions and 2045 for the wider NHS Carbon Footprint Plus.

Governance, delivery and next steps

The Group Board holds overall accountability for the Estates Operational Delivery Plan. Scrutiny is identified through Finance and Performance, Quality, People and Integration Committees, with system alignment supported through neighbourhood and wider partnership governance. Delivery will

be progressed through programmes, feasibility studies, Development Control Plans, capital prioritisation and business cases.

- Finalise the implementation roadmap and sequence priority feasibility/business-case work against service strategy and available capital.
- Establish confirmed baselines, targets and accountable owners for the benefits framework before it is used for formal performance assurance.
- Continue NHSPS asset-transfer due diligence and bring any proposed transfers through the appropriate approval process.

Provide regular Board assurance on delivery, risk, capital, benefits and changes to strategic priorities

Recommendations

This paper seeks approval of the LCHG Estates Long Term Delivery Plan 2026-2036 as the delivery framework for estate development, investment and optimisation across the Group. It brings together the strategic context, operational priorities, expected benefits, risks and delivery arrangements for Board consideration.

- Approve the LCHG Estates Long Term Delivery Plan 2026-2036 as the delivery framework guiding estate development and investment over the next ten years.
- Endorse the direction to shift appropriate services from acute hospitals into community and neighbourhood settings, supported by estate optimisation and system partnerships.
- Support progression of the priority schemes identified in the plan, including Boston CDC, Lincoln Acute Floor Programme, maternity redevelopment, Grantham elective theatre development, Louth Assessment and Admissions Unit, Skegness UTC, and critical infrastructure/backlog reduction programmes. Progression does not constitute approval of individual schemes, which remain subject to business case, affordability and formal approvals.
- Endorse continued exploration of NHS Property Services asset transfers, subject to due diligence, affordability, compliance, risk and approvals.
- Note the material backlog, compliance and infrastructure risks and support a phased, risk-based programme of prioritised investment, rationalisation and utilisation improvement.
- Require regular Board assurance on implementation, benefits, capital, backlog, community activity transfer, carbon reduction and delivery risks.

Appendix A: **Benefits Realisation Plan**
The following Benefits Realisation Plan is a suggested governance and assurance schedule. The benefits are derived directly from the objectives contained within the LCHG Estates Long Term Delivery Plan.

Benefits Realisation Plan 2026-2036

Benefit Area	Expected Benefit	Measure / KPI	Baseline (2026)	Target	Executive Owner	Delivery Lead	Review Frequency	Target Timescale
Care Closer to Home	Reduction in patient travel through neighbourhood care, CDCs and community services	Annual patient travel miles for outpatient activity	c.16 million miles per annum	50% reduction	Dep CEO	Programme Director Estates & Transformation	Qtr	2031
Care Closer to Home	Increased community-based activity	% outpatient and diagnostic activity delivered outside acute sites	Baseline TBC	Annual increase	Dep CEO	Community Transformation Director	Qtr	2028-2036
Health Inequalities	Improved access for rural and coastal populations	Activity delivered within Core20 and deprived locations	Baseline TBC	Year-on-year growth	Dep CEO	Neighbourhood Board	6 mth	2031
Community Estate Optimisation	Better utilisation of community estate	Community estate utilisation rate (%)	To be established through utilisation review	>85% utilisation	Group Chief Estates & Facilities Officer	Dep Chief Estate & Facilities Director	Qtr	2029
Estate Rationalisation	Reduction in unused estate and running costs	Square metres released, consolidated or repurposed	Baseline to be established	Annual reduction	Group Chief Estates & Facilities Officer	Estates Operational Delivery Team	Qtr	2031
NHSPS Asset Transfer	Improved estate control and investment capability	Number of transferred "Core" NHSPS assets	0	Transfer programme completed subject to approvals	Group Chief Executive	Chief Estates & Facilities Director	Qtr	2028

Acute Hospital Transformation Benefits

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Delivery Lead	Timescale
Acute Flow Improvement	Improved patient flow	Average length of stay	Current performance	Reduction against annual operational plans	Chief Operating Officer	Acute Flow Programme Director	2028
Acute Floor Programme	Improved clinical adjacencies	Clinical pathways co-located as planned	Existing fragmented layout	Delivery of Acute Floor Programme	Chief Operating Officer	Acute Floor Senior Responsible Owner	2030
Emergency Care	Reduced delays in emergency pathways	Emergency flow metrics	Existing baseline	Annual improvement	Chief Medical Officer	Emergency Care Programme Lead	2028-2031
Elective Care	Increased elective productivity at Grantham	Theatre utilisation percentage	Baseline to be established	Annual increase	Chief Operating Officer	Elective Care Board	2031
Elective Care	Reduced elective cancellations	Number of cancelled procedures	Current baseline	Annual reduction	Chief Operating Officer	Theatre Programme Lead	2031
Maternity Modernisation	Improved patient and staff environment	Compliance against current standards	Existing baseline	Full compliance achieved	Chief Nurse	Maternity Programme Director	2030

These benefits align with the proposed acute floor developments, maternity upgrades, theatre modernisation and elective hub model described within the plan.

Financial Benefits

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Timescale
Estate Efficiency	Reduced maintenance expenditure	Annual maintenance cost	Current spend	Progressive reduction	Chief Estates & Facilities Director	2031
Utilities Efficiency	Reduced energy and utility costs	£ expenditure on energy	Current baseline	Annual reduction	Chief Estates & Facilities Director	2031
Estate Benchmarking	Restation of identified Model Hospital opportunities	£ savings delivered	£0 realised	Delivery against identified opportunities	Chief Estates & Facilities Director	2030

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Timescale
Space Management	Reduced vacant and underutilised space	m² vacant/underutilised	Existing acute vacancy and underutilisation	Reduction year-on-year	Chief Estates & Facilities Officer	2029
Asset Optimisation	Capital receipts from disposal or repurposing	£ receipts achieved	£0	Business-case dependent	Chief Estates & Facilities Director	2031

The plan identifies benchmarking opportunities related to estate maintenance, water and waste spend together with improved estate utilisation.

Estate Quality and Risk Reduction Benefits

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Timescale
Backlog Maintenance	Reduction in total backlog	£137.4m reported backlog	Annual reduction	Significant reduction by 2036	Chief Estates & Facilities Officer	2036
Critical Infrastructure	Reduced estate failures	Number of critical infrastructure incidents	Current baseline	Reduction year-on-year	Chief Estates & Facilities Officer	Ongoing
Compliance	Improved statutory compliance	PAM compliance ratings	Current PAM scores	Top quartile improvement	Group Chief Estates & Facilities Officer	2030
Safety	Reduced high-risk estate issues	Number of high-risk risks on BAF and Risk Registers	Current baseline	Reduction year-on-year	Chief Estates & Facilities Officer	Ongoing
Resilience	Improved emergency resilience	Business continuity compliance measures	Baseline	Full compliance	Chief Operating Officer	2030

Workforce and Organisational Benefits

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Timescale
Agile Working	Increased utilisation of digital and agile working arrangements	Staff occupancy reductions in office space	Baseline to be established	Improvement year-on-year	Chief People Officer	2029
Staff Experience	Improved staff survey estate scores	NHS Staff Survey measures	Current score	Improvement year-on-year	Chief People Officer	Annual
Recruitment & Retention	Improved recruitment and retention in	Vacancy and turnover measures	Baseline	Improvement against workforce plan	Chief People Officer	2031

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Timescale
	modernised facilities					
Digital Enablement	Improved digital maturity	PAM / Digital Maturity Index	Current baseline	Target maturity level achieved	Chief Digital Information Officer	2030

Sustainability and Net Zero Benefits

Benefit Area	Expected Benefit	Measure / KPI	Baseline	Target	Executive Owner	Timescale
Carbon Reduction	Reduced estate carbon emissions	tCO_2e annual emissions	Carbon baseline under development	Annual reduction trajectory	Group Chief Estates & Facilities Officer	2040
Energy Efficiency	Reduced energy intensity	kWh/m^2	Current baseline	Reduction year-on-year	Chief Estates & Facilities Officer	2031
Sustainable Travel	Reduced patient travel emissions	Outpatient travel miles	16m miles	50% reduction	Chief Operating Officer	2031
EV Programme	Increased EV infrastructure and fleet transition	% EV fleet	Current baseline	Annual increase	Chief Estates & Facilities Officer	2030
Green Plan Delivery	Delivery of Green Plan milestones	% milestones achieved	Baseline	100% delivery	Chief Estates & Facilities Officer	Annual

These benefits align to the Group Green Plan and Net Zero commitments contained within the Estates Operational Delivery Plan.

Board Assurance and Reporting

The Board should receive a six-monthly Estates Long Term Delivery Plan Benefits Realisation Report summarising:

- RAG status of each strategic benefit.
- Benefit forecast versus actual delivery.
- Capital investment delivered versus plan.
- Estate backlog reduction achieved.
- Community activity transfer achieved.
- Carbon reduction progress.
- Risks to benefit realisation and mitigation actions.
- Recommended reporting route:
- Programme Boards → Estates Operational Delivery Plan Steering Group
- Finance & Performance Committee
- Integration Committee
- Quality Committee (for safety-related measures)

Group Board
This would provide a Board-ready delivery and assurance framework linked directly to the plan's objectives of estate modernisation, the "Left Shift", system integration, sustainability and reduction of backlog maintenance.



NHS
Lincolnshire Community and Hospitals NHS Group

Group Estates Long Term Delivery Plan

2026 - 2036

October 2026

Contents

1. Introduction

2. Where are we now?

2.1 Group overview
2.2 Population and demographics
2.3 Overview of our existing estate
2.4 Key sites
2.5 Existing spatial adjacencies and flow
2.6 Estate condition and backlog maintenance
2.7 Space utilisation
2.8 Estate efficiency
2.9 Current estate performance – Premises Assurance Model
2.10 Model Health System benchmarking
2.11 Transport and travel
2.12 Digital transformation
2.13 Site considerations
2.14 Energy
2.15 Financial and environmental impact
2.16 Leadership and governance
2.17 Space management and agile working
2.18 Capital expenditure and project successes
2.19 Capital plans
2.20 SWOT analysis

3. Where do we want to be?

3.1 Overview
3.2 National context
3.3 Regional context
3.4 Local drivers for change
3.5 Implications for our Estate Strategy
3.6 Engagement

4. How do we get there?

4.1 Strategic options
4.2 Project sequencing, phasing and design
4.3 Funding and resourcing
4.4 Estate capital and development roadmap
4.5 Governance
4.6 Sustainability and Net Zero
4.7 Risk management and liability

5. Conclusion and next steps

5.1 Future strategic intent
5.2 Shifts to community and neighbourhood estate
5.3 Optimisation of the acute sites
5.4 Post plannext steps

Appendices

Version **control**

V	Description	Date
V1	Archus first draft (headings only)	April 2026
V1	Where are we now section only	08/05/2026
V1	Where do we want to be and how do we get there sections only	22/05/2026
01	Full document	16/06/2026
02	Full document	16/07/2026
10	Revision following comments	27/07/2026
10b	Format check and colour revision	30/07/2026
3.0	Full document	03/08/2026
04	Final document for submission	28/09/2026

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Authorised by
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Schedule of **tables**

Table 1. Land and buildings overview, ERIC 2024/25, valuation survey February 2026 and NHSPS Condition packs received July 2026

Table 2. Five-year capital expenditure as per Group Capital Team report – figures below are exclusive of capital relating to digital and medical equipment upgrades.

Table 3. NHSPS properties (*at February 2026)

Table 4. LCHG capital allocations summary, 2026/27–2029/30

Schedule of **figures**

Figure 1. Lincolnshire deprivation map, Indices of Deprivation 2025

Figure 2. Lincolnshire Core20 population map with the highest 20% in red zones

Figure 3.Overall map of sites used to deliver LCHG services

Figure 4. Estate Return Information Collection (ERIC) 2024/25 backlog maintenance costs (Group portfolio)

Figure 5. Journey time to acute hospital services within 30 minutes by car

Figure 6. Digital exclusion and transport barriers map, from Lincolnshire ICB Infrastructure Plan2024-2034

Figure 7. Space management and agile working enablers

Figure 8. Where are we now SWOT analysis

Figure 9. Better Lives Lincolnshire – Integrated Care Partnership Planpriorities and enablers

Figure 10. Lincolnshire ICS map and partners

Figure 11. Lincolnshire ICB immediate priorities that link with LCHG future estate

Figure 12. Lincolnshire ICB transformational schemes that link with LCHG future estate

Figure 13. Lincolnshire Primary Care Network geography

Figure 14. Strategic aims and objectives

Figure 15. Collaborative operating model

Figure 16. One Digital Strategy

Figure 17. Group Estates Long Term Delivery Plan strategic objectives

Figure 18. Stakeholder workshop findings informing the Plan, May–June 2026

Figure 19. Roadmap

Figure 20. Implementation roadmap

1. Introduction

The Lincolnshire Community and Hospitals Group (LCHG) Estates Long Term Delivery Plan 2026–2036 supersedes the previous Estate Strategy and sets out the framework for developing, managing and improving the estate over the next decade. It retains the established strategic direction while translating clinical and organisational priorities into investment priorities, phased delivery programmes and measurable outcomes.

The Plan brings together estate modernisation, backlog maintenance, statutory compliance, sustainability and improved space utilisation to enable care closer to home and more efficient acute services. It will be reviewed regularly to reflect changing service requirements and funding opportunities. Individual schemes remain subject to business case approval, affordability assessment and established governance processes.

The Plan follows NHS guidance and addresses three questions:

Where are we now? | **Where do we want to be?** | **How do we get there?**

This plan has been produced in the context of the findings of Sir Robert Naylor's review of NHS property and estates (2017). Briefly, the outcome of this review was the requirement for NHS Trusts to develop estate strategies, masterplans and capital plans that align with their clinical strategies, maximise value for money (including land sales) and address backlog maintenance costs and issues.

The Plan aligns with national guidance, including the Department of Health's Developing an Estates strategy (2015), and reflects best practice in long term planning, governance and clinical transformation. It also supports the Lincolnshire Integrated Care System's (ICS) Strategy and capital prioritisation framework, including regional ambitions for integration, population health improvement and efficient use of public sector assets.

The Plan supports the National Neighbourhood Health Implementation Programme (NNHIP), part of the 10-Year Plan (2026), by enabling integrated neighbourhood teams, proactive care closer to home and the transfer of appropriate services from hospital to community settings. It identifies the infrastructure needed to support high-impact interventions for people with long term conditions and reduce health inequalities. As an Anchor Institution, the Group will work with partners to improve population health and deliver wider social value.

The previous two-year Estate Strategy was produced during COVID-19 to address urgent priorities. This Plan builds on the investment delivered over the past five years through the capital programme supporting the 2022 Strategy and sets the direction for estate development to 2036.

The Plan supports the provision of safe, secure, high-quality healthcare buildings that meet current and future service needs. It sits alongside the Group's other strategic planning documents and sets out:

- Our long-term vision for an efficient, sustainable and clinically fit for purpose estate.
- An assessment of our current estate through an analysis of its condition and performance.
- The intended outcomes by 2036: a more sustainable, better utilised estate with reduced backlog maintenance, enabling care closer to home, efficient acute services and modern environments for patients and staff.

The Plan should be read alongside the Technical Appendix (Appendix A), which provides the detailed data and supporting analysis.

“Our Estates Long Term Delivery Plan sets a clear direction for creating a modern, sustainable and flexible estate that enables care closer to home, strengthens our acute hospitals and ensures every investment supports better outcomes for the people of Lincolnshire.”

Michael Parkhill

Group Chief Estates and Facilities Officer

2. Where are we now?

2.1 Group overview

In 2024, Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) formed the Lincolnshire Community and Hospitals Group (LCHG) under a single Board of Directors to improve patient care and health outcomes across the county. The Group manages three main acute hospitals, five community hospitals and a range of community facilities and support spaces and has already taken significant steps to modernise care delivery. The Group model supports coordinated planning across both Trusts; its leadership and governance arrangements are described in Section 2.16. This Plan sets out the estate development framework for 2026–2036, building on the Trust Strategy published in 2022.

Lincolnshire is the second largest county in England, covering 2,687 square miles. It is predominantly rural, with a significant coastal population. The county struggles with connectivity, with only one motorway in the north and inconsistent public transport links. As a Group, we deliver services across a combined area of approximately 1,942 square miles, spanning both acute and community care. We employ around 14,000 staff across our community and acute sites and provide healthcare services to a population of approximately 799,500 people.

We are one of the largest acute Trusts in England and work closely with partners in community health, primary care and mental health to deliver integrated care across the county. Through our partnerships with General Practice, Primary Care Networks, mental health providers, local authorities, the voluntary, community and social enterprise (VCSE) sector, and wider system partners, we are developing neighbourhood-based models of care that bring services closer to where people live. By working collaboratively across organisations, we aim to improve access, reduce health inequalities, support prevention and early intervention, and enable more residents to receive care as close to home as possible. We are also working closely with the newly formed Derbyshire, Lincolnshire and Nottinghamshire (DLN) Integrated Care Board (ICB) cluster to reduce health inequalities and improve outcomes for our population.

2.2 Population and demographics

Population

As stated above, Lincolnshire has a current (2026) population of approximately 799,500. According to the Office for National Statistics (ONS), the county experiences seasonal increases in population due to tourism and temporary work, with numbers rising to around 825,000 registered patients during the summer months. ONS projections also indicate that Lincolnshire's population is expected to grow by around 2.8% by 2031, alongside a continued increase in the proportion of residents aged 65 and over.

Deprivation

Within the county there are areas of relative affluence, particularly around Lincoln, Stamford and Grantham. However, Lincolnshire also has pockets of severe deprivation, including parts of Lincoln, Gainsborough and several coastal towns, which fall within the most deprived 10% of areas nationally according to strata data. This is noted as a priority in the new ICB Cluster 5-Year Population Health Plan (2026/2031), which is working to improve health outcomes and close the gap around health inequalities. Figure 1 displays the English Index of Multiple Deprivation (IMD) 2025 at Lower Super Output Area (LSOA)[1] level. Areas are grouped into quintiles, with darker shades of purple indicating higher levels of deprivation and lighter shades indicating lower levels of deprivation. Lincolnshire has an average IMD score of 22.24, compared with an England average of 21.67.

[1] **LSOAs (Lower Layer Super Output Areas)** are standard statistical areas created by the ONS, each containing approximately 1,000–3,000 residents, used to analyse and compare local demographic, health and deprivation data.

Figure 1. Lincolnshire deprivation map, Indices of Deprivation 2025

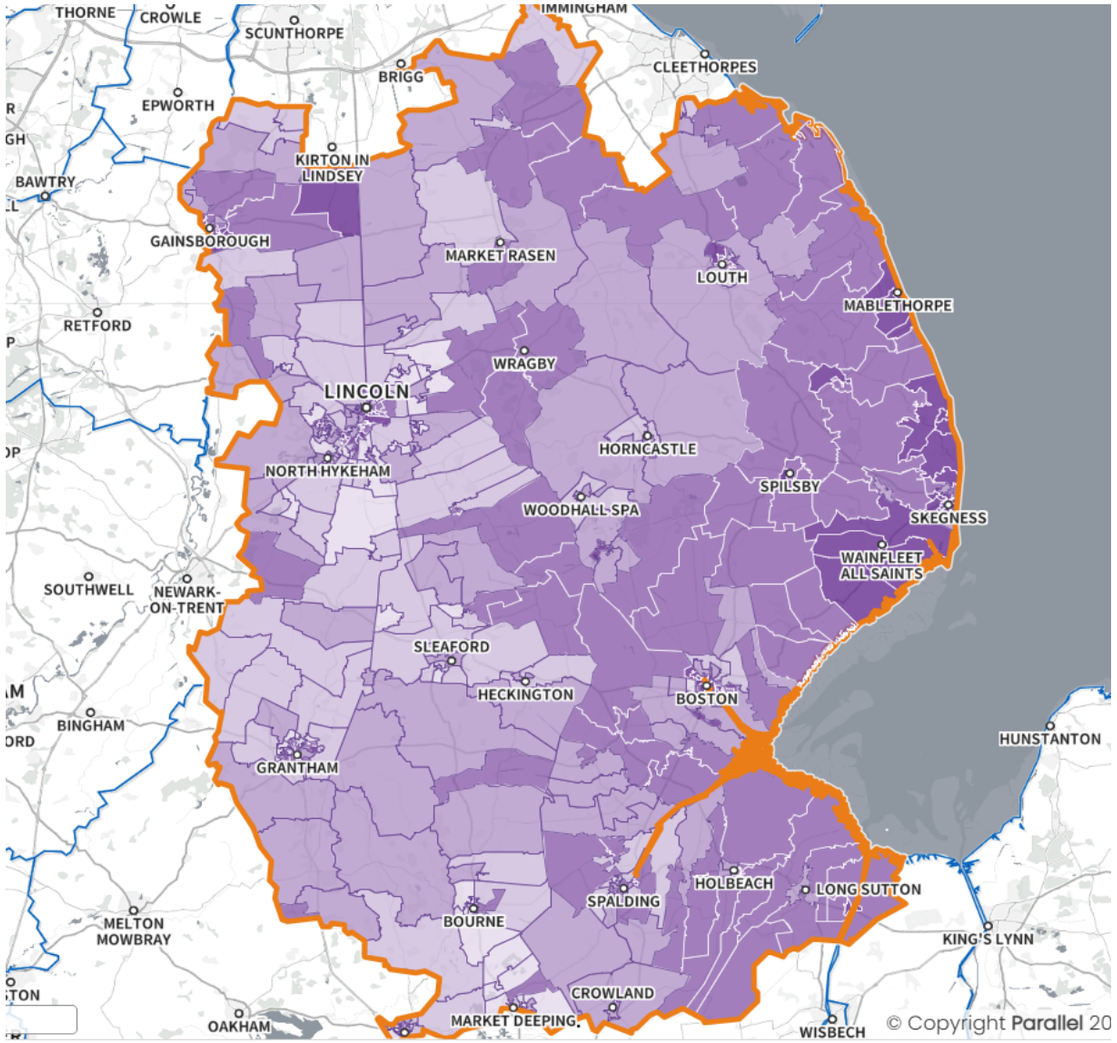
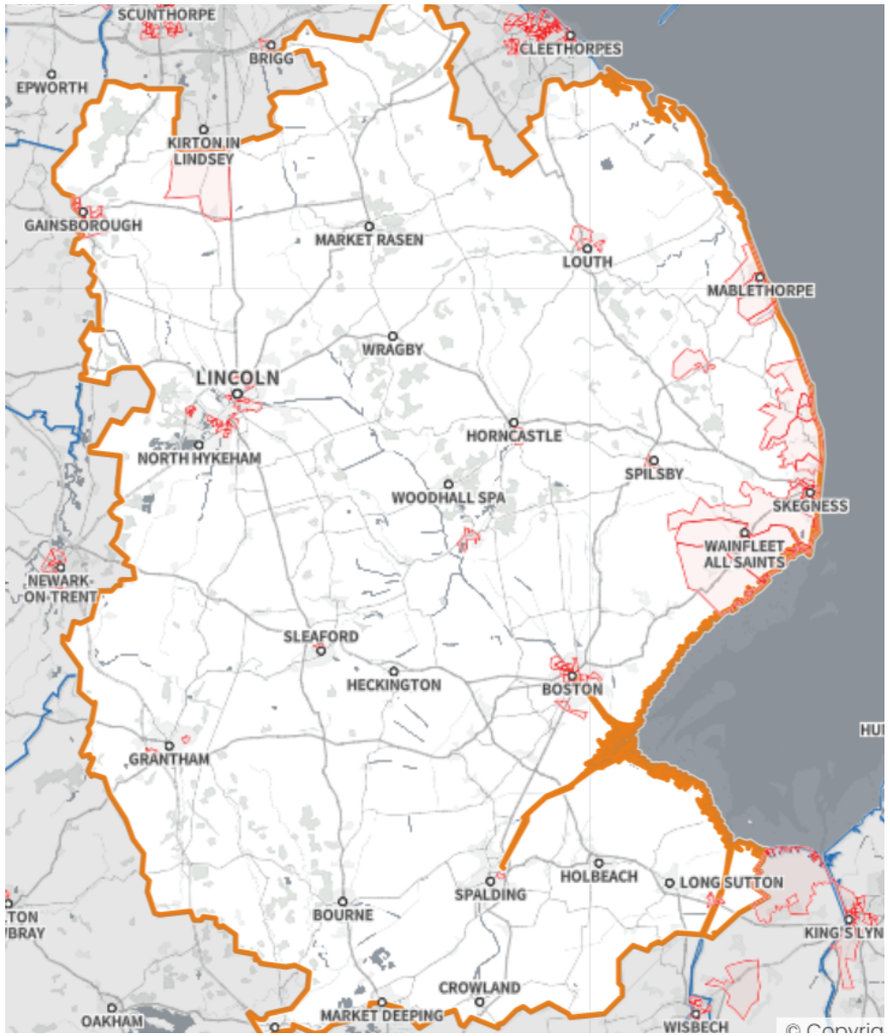


Figure 2. Lincolnshire Core20 population map with the highest 20% in red zones



Lincolnshire's overall position is broadly in line with the national average for deprivation. However, the NHS Core20PLUS5 approach has identified a target of closing health inequalities for the most deprived 20% of people, which is in the region of 110,000 in Lincolnshire. At an Integrated Care System (ICS) level, it includes target groups specific to our county, such as those in rural, coastal, farming and military personnel communities, as well as others that may find access to consistent healthcare more challenging. The areas included in the highest 20% deprivation Core20 figures are highlighted in the red zones in Figure 2.

Disease prevalence

The five most prevalent long-term conditions in Lincolnshire, as recorded through the Quality and Outcomes Framework (QOF) 2023/24, are hypertension, diabetes, chronic kidney disease, asthma and cancer, all of which are reported at higher prevalence rates than the average across comparator ICBs. In addition, musculoskeletal conditions have been identified as a significant health priority for the county due to their impact on both quality of life and demand for healthcare services.

Obesity also remains a major public health challenge. The Lincolnshire Joint Strategic Needs Assessment (JSNA, 2023) highlights notable differences in life expectancy and healthy life expectancy between men and women. Women generally live longer than men, with an average life expectancy of 82 to 83 years compared with 78 to 81 years for males; however, they spend a greater proportion of their lives in poor health. Data from the Office for Health Improvement and Disparities (OHID) further indicates that 67.9% of adults in Lincolnshire were classified as overweight or obese in 2023/24, compared with the England average of 64%.

2.3 Overview of our existing estate

As of 2026, the Group occupies 50 properties, including three acute hospitals, community hospitals and clinics, three Community Diagnostic Centres (CDCs), a fourth CDC under construction, and a range of support facilities (Figure 3). Further detail on the other sites can be found at Appendix B.

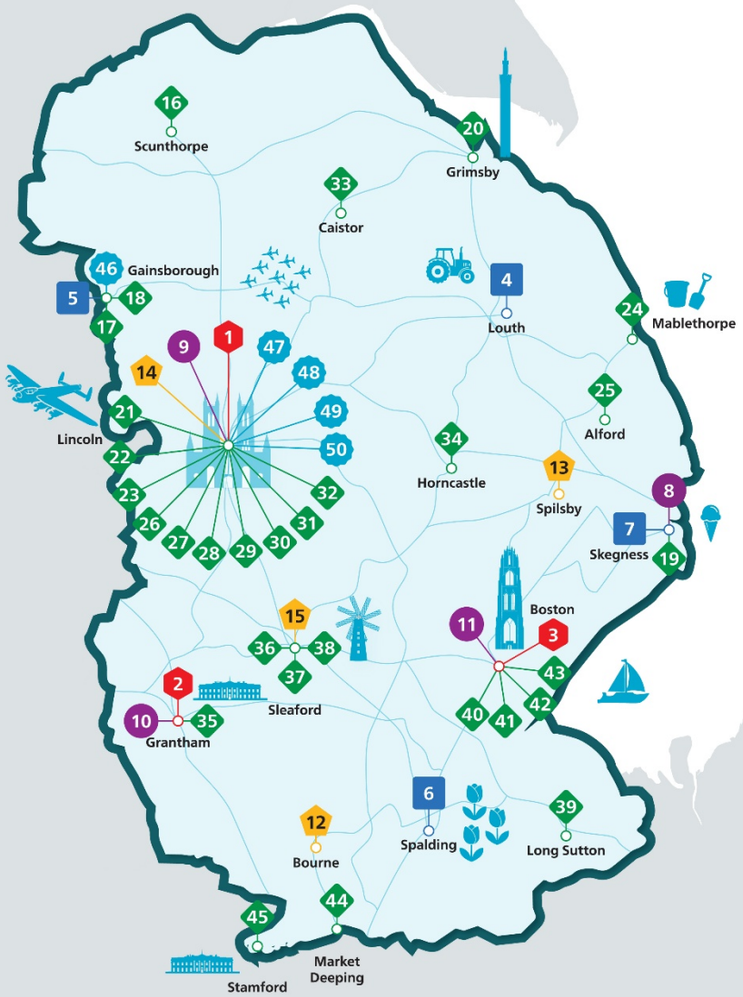
Many community properties are currently leased from NHS Property Services (NHSPS). Therefore, the backlog maintenance position presented in Table 1 does not yet reflect the full estate portfolio currently. We have submitted an expression of interest to bring these assets into Group ownership, creating a single estate management structure and transferring the associated backlog maintenance responsibilities to the Group.

Table 1. Land and buildings overview, ERIC 2024/25, valuation survey February 2026 and NHSPS Condition packs received July 2026[2]

Site	Tenure	Type	Gross Internal Area (m2)	Total Net Book Valuation	Total Backlog Maintenance
Lincoln County Hospital	Freehold	Acute	78,275	£110,343,346	£50,485,183
Pilgrim Hospital Boston	Freehold	Acute	62,106	£72,194,929	£48,234,047
Grantham and District Hospital	Freehold	Acute / Large community hospital	28,314	£28,936,675	£27,336,658
County Hospital Louth	Leased	Community hospital	5,855	£9,885,452	£5,655,858
John Coupland Hospital	Leased	Community hospital	3125	£14,097,200	£3,074,392
Johnson Community Hospital	Leased	Community hospital	3,493	£24,713,048	n/a
Skegness Hospital	Leased	Community hospital	2,388	£3,437,900	£2,584,044
Skegness CDC	Freehold	Diagnostics	934	£7,876,626	n/a
Lincoln CDC	Freehold	Diagnostics	1,723	£13,369,203	n/a
Grantham CDC	Freehold	Diagnostics	947	£1,975,380	n/a
Total			**187,160**	**£286,829,759**	**£137,370,182**

[2] Backlog values in this table reflect a combination of ERIC data and NHSPS condition information received in July 2026.

Figure 3.Overall map of sites used to deliver LCHG services



Acute hospitals

1) Lincoln County Hospital
2) Grantham and District Hospital
3) Pilgrim Hospital, Boston

Community hospitals

4) County Hospital, Louth
5) John Coupland Hospital, Gainsborough
6) Johnson Community Hospital, Spalding
7) Skegness and District Hospital

Community Diagnostic Centres

8) Skegness CDC
9) Lincoln CDC
10) Grantham CDC
11) Boston CDC

Owned LCHS properties

12) Bourne Health Clinic
13) Grace Swan Health Clinic
14) Ravendale Health Clinic
15) Riversdale Health Clinic

LCHS leased sites

16) Ironstone Centre
17) Gainsborough Children's Centre
18) Pottergate Health Centre
19) Skegness Health Clinic
20) Quayside Medical Centre
21) Newland Medical Centre
22) Enterprise Park - Unit 20
23) Enterprise Park - Unit 23
24) Marisco Medical Practice
25) Alford War Memorial
26) 63 Monks Road
27) 179 High Street, Lincoln
28) Beech House
29) Lindon House
30) Fen House
31) North Hykeham Health Clinic
32) Birchwood Health Centre
33) Caistor Health Centre
34) Horncastle War Memorial Centre
35) Grantham Health Clinic
36) Unit 14
37) Unit 15
38) Unit 7
39) Long Sutton Medical Centre
40) Venture House
41) The Sidings Medical Centre
42) Boston Health Clinic
43) Butterfly Hospice
44) The Deepings Health Centre
45) Stamford and Rutland Hospital

ULTH leased sites

46) Gainsborough Health Clinic
47) Unit 1, Greetwell Road
48) Unit 1, Boole Technology Centre
49) Pinnacle House
50) Warehouse 6/Denby

2.4 Key sites

Acute sites

Lincoln County Hospital

Lincoln County Hospital is the principal and largest acute site within our portfolio, serving the population of the City of Lincoln and surrounding rural areas. The site supports a wide range of services including paediatrics, adult medicine and surgery, maternity, intensive care and high dependency care. While the site has been continually expanded and adapted, parts of the infrastructure are now ageing, and significant investment is required to modernise facilities and support contemporary models of care.

Owned/managed	Age of site	Bed provision (approx.)
ULTH/ULTH	1960 with main building opened in 1980	600

Pilgrim Hospital, Boston

Pilgrim Hospital is our second largest hospital, the original tower block forms the core of the site, which has since been expanded through a series of subsequent developments. The hospital serves the town of Boston and a large, predominantly rural, catchment area. It delivers a broad range of services including adult medicine and surgery, children's and young people's services, acute and emergency care, women's health and critical care. While parts of the estate face challenges associated with ageing infrastructure, significant recent investment has been made, most recently being the new emergency department.

Owned/managed	Age of site	Bed provision (approx.)
ULTH/ULTH	1970	390

Grantham & District Hospital

Grantham District Hospital operates as a large local general hospital, providing urgent care, inpatient services, diagnostics and outpatient clinics including maternity. Unlike Lincoln County Hospital and Pilgrim Hospital, it is not a full acute emergency site, instead supporting the wider system by delivering planned care, lower acuity services and step-down care. As well as developments like the two newly built modular theatres (2022), significant internal investment during the COVID-19 period has resulted in a clean, modern and well-maintained environment throughout the hospital.

Owned/managed	Age of site	Bed provision (approx.)
ULTH/ULTH	1935 with major developments in 1970s	180

Community sites

Louth County Hospital

Originally a workhouse, Louth County Hospital is a long-established site comprising buildings developed over many years. As a result, the estate includes a mix of older and newer facilities rather than a single purpose-built hospital. The hospital provides a range of local inpatient, outpatient, minor surgery and community services, supporting care closer to home for the local population. While the site remains operational, the age and layout of parts of the estate present ongoing challenges. Some older buildings are difficult to upgrade due to design limitations and Grade II listing restrictions. Despite these constraints, Louth County Hospital continues to play an important role in local service delivery.

Owned/managed	Age of site	Bed provision (approx.)
LCHS/NHSPS	1837 original, 1960 main block, 1990s New block	24

Skegness Hospital

Skegness Hospital is an established local healthcare facility made up of buildings developed incrementally over time rather than a single purpose-built structure. The original part of the estate continues to house the urgent treatment centre, which experiences significant seasonal pressure due to increased demand during peak summer tourism.

The hospital provides a range of outpatient, diagnostic and community-based services. While the site functions effectively overall, the age and layout of some buildings present constraints when accommodating modern service requirements. Nevertheless, Skegness Hospital remains a vital part of the local health system and plays a key role in providing community-based care.

Owned/managed	Age of site	Bed provision (approx.)
LCHS/NHSPS	1913 original, recent additions in 1990	39

John Coupland Hospital

The original John Coupland Hospital building has undergone several extensions over time and now delivers a range of services including an urgent treatment centre, diagnostic services, minor surgery, outpatient clinics, therapies and other community support services.

The hospital also accommodates the Scotter Ward, a transitional care unit providing services such as palliative care and stroke rehabilitation. While the site continues to operate effectively, elements of the estate are constrained by ageing infrastructure, which will need to be addressed to support modern healthcare delivery.

Owned/managed	Age of site	Bed provision (approx.)
LCHS/NHSPS	1913 with new ward open in 2024	17

Johnson Community Hospital

The Johnson Community Hospital is a modern, purpose-built facility under the Private Finance Initiative (PFI), serving Spalding and the surrounding areas. The hospital provides a range of community services, including an urgent treatment centre, minor surgery, outpatient clinics, diagnostic services and rehabilitation.

The site includes an inpatient unit, supporting rehabilitation following acute hospital care, as well as end of life and palliative care services. The modern design and layout of the hospital provide a flexible environment that supports contemporary models of care.

Owned/managed	Age of site	Bed provision (approx.)
LCHS/NHSPS	2009	32

Other sites

Some of the newest assets within our estate are the purpose-built CDCs located in Lincoln, Grantham and Skegness, with a further centre in Boston currently in the early stages of construction. Since the opening of the CDCs in Grantham in 2022 and in Skegness and Lincoln in 2024, several thousand patient appointments have been moved away from the acute hospital sites. These modern, fit for purpose facilities are efficient, are supporting improved patient flow and have received very positive feedback from patients across the County.

In addition to the CDCs, the estate includes a broad mix of community care centres, walk in treatment centres and leased accommodation shared in other public sector buildings such as universities, colleges and local authority buildings, as well as storage and warehouse facilities. These community properties support the delivery of a wide range of local services, including podiatry, diabetic support, maternity care and children and young people’s services. They also enable close collaboration with Primary Care and Mental Health partners to ensure services are delivered in the most appropriate settings for local populations.

2.5 Existing spatial adjacencies and flow

Incremental development across acute and community sites has resulted in fragmented layouts and inefficient connections between services. These constraints affect patient movement, navigation and service delivery.

Moving appropriate activity into community settings will create opportunities to reconfigure released space, improve clinical adjacencies and support more efficient care delivery. Patient feedback will inform improvements to signage and wayfinding for staff, patients and visitors.

Development Control Plans

Development Control Plans (DCPs), prepared with an architect as part of the Plan, identify potential development areas and map estate condition across key sites. They will inform future projects, improve clinical adjacencies and support investment decisions. The DCPs are provided in Appendix C.

2.6 Estate condition and backlog maintenance

A comprehensive Six Facet Survey was conducted across the acute estate between July and November 2023 to assess physical condition, statutory compliance and associated risk.

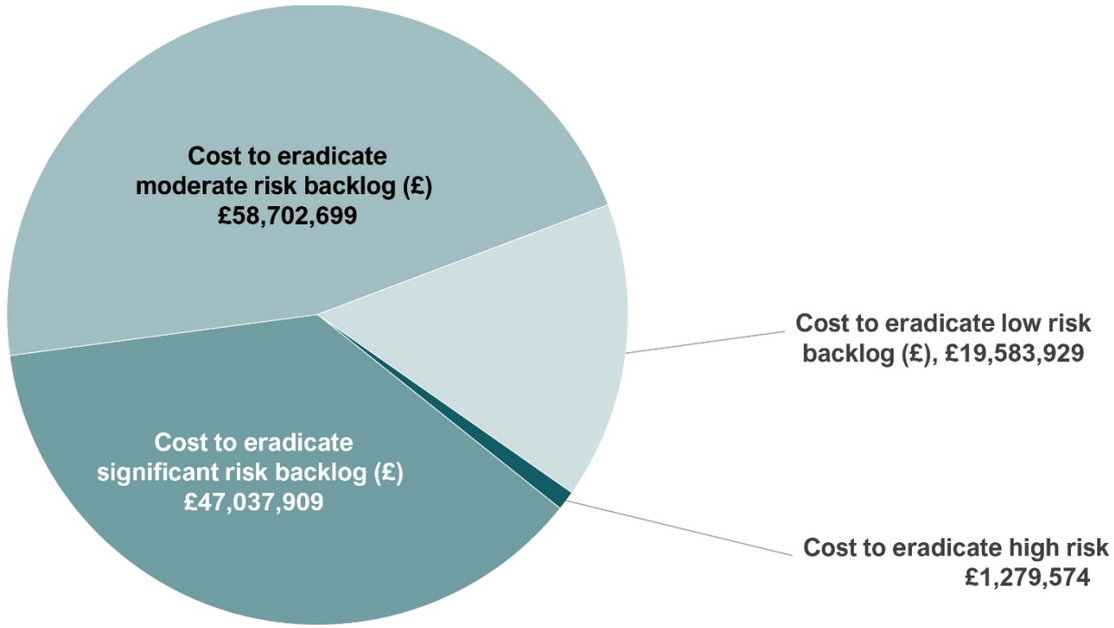
The survey revealed significant areas of the estate requiring modernisation, risk reduction and sustainability upgrades, alongside a substantial backlog of maintenance required to bring the estate up to a sound, operationally safe condition (Grade B).

[1] A Six Facet Survey (2023) identified significant backlog maintenance and compliance pressures across the acute estate. Subsequent ERIC returns indicate the backlog requirement has increased to approximately £126.6m, with a further 2025/26 submission of £130.8m (not yet published at the time of writing).

Backlog reporting clarification required: Table 1 combines ERIC 2024/25 data and NHSPS condition information received in July 2026, reporting £137.370m. The approximately £126.6m and £130.8m figures above relate to subsequent ERIC returns, with the 2025/26 submission unpublished at the time of writing. Portfolio scope and reporting dates require reconciliation before these figures are compared.

Understanding the physical condition of our estate is critical to ensuring patient safety, operational resilience and the effective allocation of capital[1]. The backlog split across each of the sites and a peer comparison among similar-sized Trusts can be found in the Technical Appendix.

Figure 4. Estate Return Information Collection (ERIC) 2024/25 backlog maintenance costs (Group portfolio)



***NOTE**. Critical Infrastructure Risk is combined total of the High and Significant risk categories*

2.7 Space utilisation

Improving space utilisation will support patient flow, staff working environments and lower overheads. The Six Facet Survey and ongoing operational assessments show congestion in parts of the acute estate alongside underused capacity elsewhere, particularly within fragmented and leased community premises.

Addressing this imbalance will enable appropriate care to move into community and neighbourhood settings, release acute space for priority services and improve local access.

Our strategic approach to improving space utilisation focuses on:

- repurposing released acute space following the shift of outpatient, diagnostic and preventative activity into community settings
- consolidating underused or poor-quality community estate to create more efficient service hubs
- increasing the use of flexible, shared and multi-agency spaces that can adapt to changing service models.
- maximising shared use of estate with partners to support neighbourhood health services
- utilising AI to reduce administrative burden and increase staff time for direct patient care.

Improved monitoring, booking and shared-space management will support a more flexible and responsive estate.

A detailed assessment of space utilisation, including key challenges, methodology and supporting data, is provided in the Technical Appendix.

2.8 Estate efficiency

Estate efficiency is essential to productivity and long-term financial sustainability. The fragmented footprint and reliance on legacy infrastructure increase the complexity and cost of estate management.

Baseline assessments identify high operating costs, particularly for ageing mechanical and electrical systems. Investment and maintenance decisions must therefore consider operational efficiency as well as infrastructure condition.

The 2024/25 Estate Return Information Collection (ERIC) returns show the scale of the portfolio and how capital is deployed to maintain and improve it. Detailed analysis is provided in the Technical Appendix; space utilisation is addressed in Section 2.7.

2.9 Current estate performance – Premises Assurance Model

The NHS Premises Assurance Model (PAM) provides a standardised framework to assess the safety, efficiency and effectiveness of our healthcare estate. The 2024/25 PAM submissions for both the acute (ULTH) and community (LCHS) arms of the Group provide a clear baseline of current performance, highlighting areas of strong operational practice alongside critical gaps that this ELTDP must address.

The PAM findings demonstrate the need for unified estate management across the Group and inform the Plan's priorities for:

- **Risk reduction and compliance**: Establishing fully costed action plans to address hard facilities management (FM) technical compliance and statutory safety gaps across both Trusts.
- **Modernisation and digitalisation**: Addressing the low digital maturity within community estate management to improve oversight, resilience and asset management.
- **Integrated FM structure**: Moving away from silo structures to a consolidated, Group-wide approach to FM to ensure consistent standards, robust governance and accurate statutory appointments.
- **Sustainability planning**: Improving effectiveness in sustainability and planning within the acute estate to align with the Group's Green Plan and Net Zero ambitions.

The Technical Appendix provides the breakdown for each Trust.

2.10 Model Health System benchmarking

NHS England's Model Hospital benchmarking provides a complementary view of estate performance and productivity. Although derived primarily from ERIC submissions, Model Hospital applies additional national benchmarking methodologies and should therefore be interpreted as a comparative performance tool rather than a direct replication of ERIC reported values.

Within the community estate (LCHS), general administration accommodation accounts for 16.1% of occupied floor area (space currently in operational use) compared with a peer average of 4.7%, indicating opportunities to further support agile and digitally enabled models of working. Within the acute estate (ULTH), 4.9% of floor area (8,034m²) is reported as vacant, with a further 1,280m² classified as under-utilised.

Benchmarking identifies potential opportunities of approximately £5.0m in estates and property maintenance, £338k in water and sewage costs and £483k in waste management costs. These are comparative indicators, not confirmed savings; deliverable benefits will require assessment against local requirements and costs.

These findings support the strategic objectives of improving utilisation, reducing operational costs and modernising estate management practices. See Appendix D for the full Model Hospital reports (May 2026).

2.11 Transport and travel

A Group Travel Plan has been initiated to assess how staff, patients and visitors travel to our sites. In line with the Green Plan, work includes exploring park-and-ride options and continuing upgrades to electric vehicle infrastructure.

Car parking and site access

Car parking pressures vary across our sites. Some benefit from ample parking provision, while others experience regular congestion. Grantham Hospital has over 200 parking spaces, which generally meets demand for the services provided. Similarly, Pilgrim Hospital, with more than 440 spaces, and Lincoln County having 540 spaces, parking is well catered for on these sites.

Across some of our community hospitals, particularly at Skegness car parking is a recurring challenge during periods of increased activity. Louth and John Coupland also report issues with parking when a higher level of activity occurs. In contrast, Johnson Community Hospital is a recently opened, purpose-built facility and benefits from ample car parking, which is free for both staff and visitors. Other sites across our portfolio have varying levels of parking capacity depending on their size and usage.

Staff travel

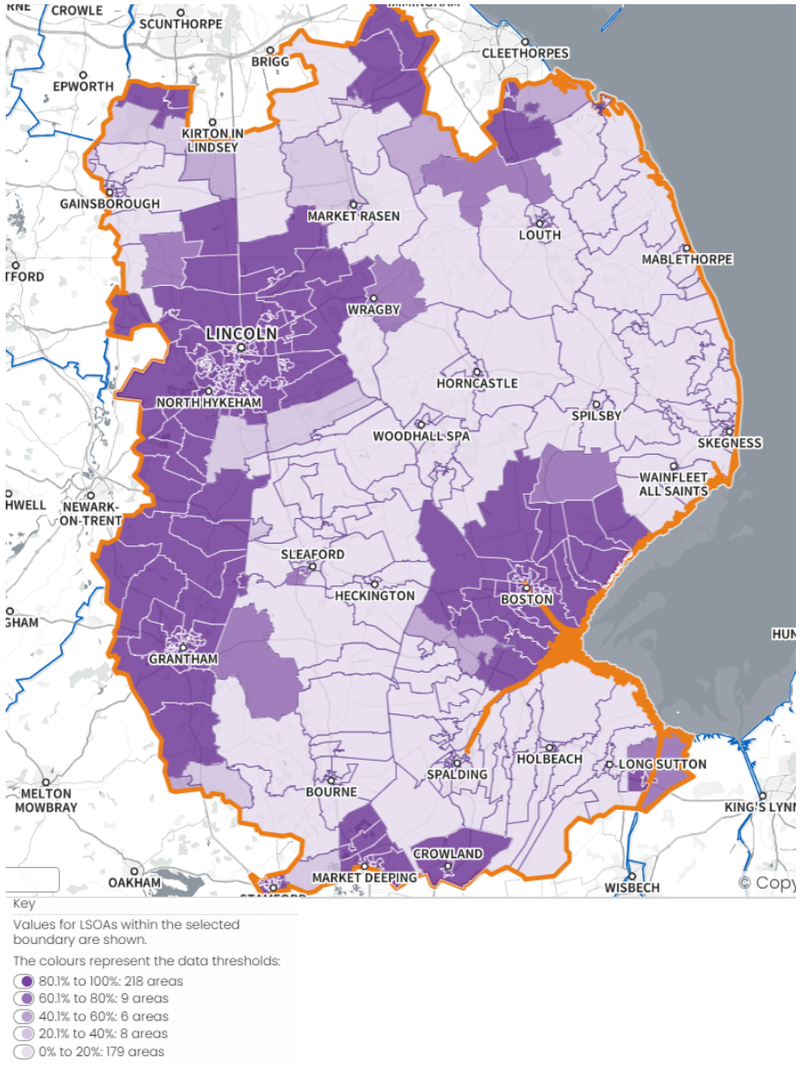
We encourage our staff to use public transport, walk, or cycle where possible. Staff also have access to salary sacrifice cycle-to-work schemes, allowing them to purchase bikes for commuting while saving on tax and National Insurance. These schemes are managed through staff wellbeing services to promote sustainable travel. However, due to Lincolnshire's rural geography, this is not always feasible. To support essential travel between sites, there is a fleet of pool cars available for short, critical journeys. These vehicles are in the process of being transitioned to electric models in support of our net zero ambitions. In parallel, work is underway across several sites to install electric vehicle charging points.

Patient travel

In a recent study, we identified that patient travel for medical treatment across the county accounts for approximately 16 million miles each year for outpatient appointments alone. In line with the NHS 10-Year Plan, we aim to reduce this significantly by delivering more care closer to home.

Work is currently underway across the Group to establish the CO_2 emissions baseline, including emissions associated with patient travel. This will help identify opportunities to reduce emissions and support delivery of our sustainability and green plan objectives.

Figure 5. Journey time to acute hospital services within 30 minutes by car



Accessibility to hospital services by sustainable transport is a particular challenge across Lincolnshire. Only 54.79% of households are able to access a hospital within 60 minutes by public transport or walking. This compares to an England-wide average of 84.9%, highlighting the significant disparities in access experienced by our population.

Patient travel within Lincolnshire can be challenging due to the county's geography and infrastructure. In more sparsely populated areas, transport connectivity is limited, with some roads being narrow or in poor condition. Public transport options are often infrequent, particularly in rural areas and coastal towns, making travel unreliable for patients who need to attend appointments at specific times.

Furthermore, only 53.28% of households in Lincolnshire can access an acute hospital within 30 minutes by car, compared to an England-wide average of 88.7% across Lower Layer Super Output Areas (LSOAs)[3]. The map (figure 5) illustrates this disparity, with lighter purple areas indicating poorer access to acute hospital services. When overlaid with deprivation data, particularly across coastal communities, it highlights priority areas where access to healthcare services should be improved.

2.12 Digital transformation

Digital transformation is a core enabler of our clinical and operational plans, supporting the national move from analogue to digital services. For a geographically dispersed community hospital estate, reliable digital infrastructure is essential to maintaining consistent care, supporting multidisciplinary working across sites and improving access for patients.

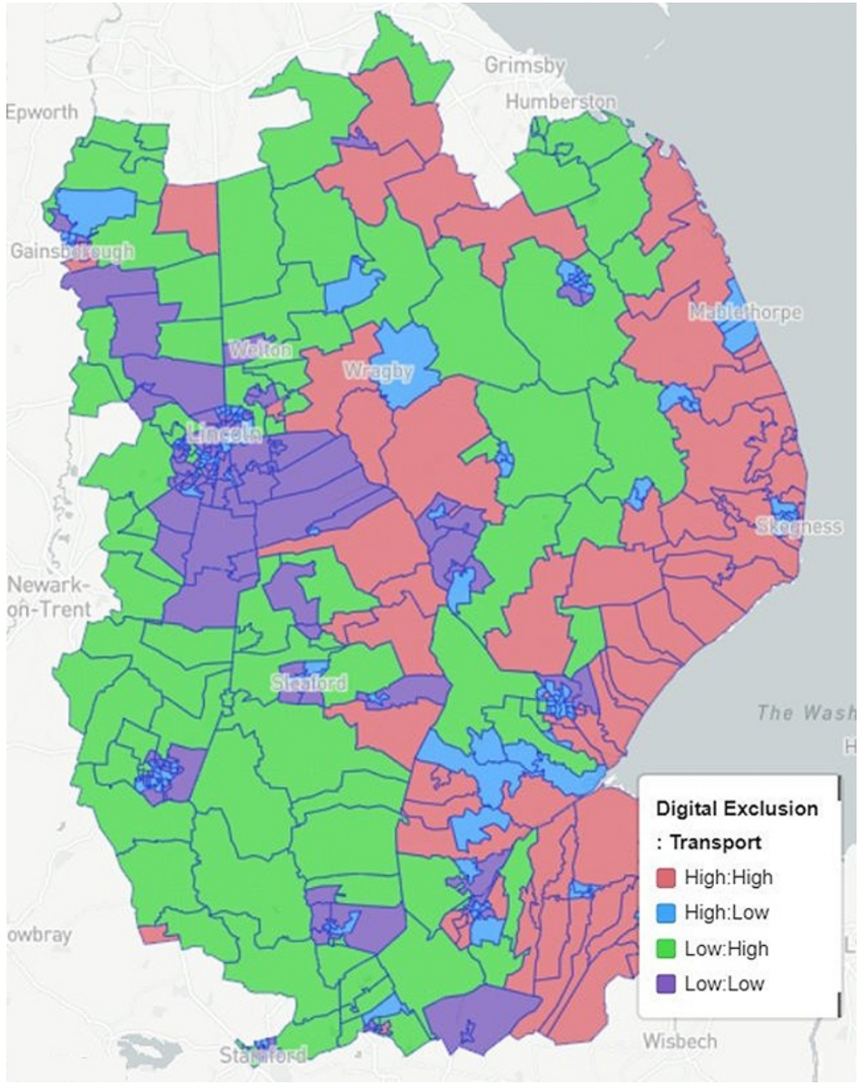
Digital exclusion remains a significant issue in Lincolnshire. Rural geography and dispersed settlements contribute to variable mobile and broadband coverage, while some households experience affordability challenges, limited access to devices or lower digital confidence. Additional barriers exist for people with sensory impairment, learning disability, cognitive impairment or limited English. As a result, uptake of digital services is uneven, with ongoing reliance on telephone and face-to-face contact and continued support from carers, families and community organisations.

Estate-related constraints, including inconsistent connectivity, limited resilience of power and communications infrastructure and accommodation not designed for hybrid or virtual delivery, further affect productivity, patient experience and information governance. Figure 6 illustrates

how digital exclusion and transport barriers vary across the county, reinforcing the need for targeted, place-based responses.

We are embracing digital transformation, including the use of artificial intelligence (AI), to support more efficient, integrated and patient-centred care, with further detail on our future digital ambitions set out in Section 3, *One Digital Strategy*.

Figure 6. Digital exclusion and transport barriers map, from Lincolnshire ICB Infrastructure Plan2024-2034



2.13 Site considerations

Listed buildings

A small number of sites within our estate include listed buildings. At Lincoln County Hospital, some of the original buildings are Grade II listed, most notably the former nurses' home, which dates to approximately 1915. Louth County Hospital also includes Grade II listed buildings, including the former workhouse constructed in 1837, along with several buildings of historic interest within the curtilage of the site.

Conservation areas

There are currently no designated conservation areas across the portfolio. However, several sites include features of local environmental or historical importance. Pilgrim Hospital in Boston is located adjacent to Dion's Wood Nature Reserve, a 35-acre green space that is recognised for its ecological value, although not legally listed as a conservation zone.

In addition, while not formally listed, certain buildings are regarded as being of significant local interest. These include the original hospital buildings at Grantham District Hospital and the original building at John Coupland Hospital in Gainsborough, both of which contribute to the local heritage and character of their respective sites and are seen to be of significant public interest.

Due to the rich historical landscape across Lincolnshire, some sites may be located close to conservation areas or be affected by Tree Preservation Orders (TPOs), which could place additional constraints on future development or estate activity.

2.14 Energy

Energy use across the LCHG estate is high due to the 24/7 nature of healthcare delivery and the scale and age of the portfolio, with older buildings driving increased demand and carbon impact.

ULTH demonstrates higher energy intensity than peers (c. £51.76/m² and 521 kWh/m² vs ~£45/m² and 419 kWh/m²), while LCHS performs significantly more efficiently (c. £10.13/m² and 47.84 kWh/m²). At a service level, ULTH's energy use per patient is broadly in line with benchmarks, whereas LCHS records substantially lower usage.

Across the Group, a more proactive approach to energy management is being adopted through improved monitoring, including building management systems and sub-metering, alongside targeted Green Plan interventions such as lighting upgrades, heating optimisation and low-carbon energy solutions such as the recently installed PV panels at Lincoln and Grantham hospitals with more solar schemes being explored for the future. We also have successfully bid for the Salix decarbonisation project which commences in November 2025 at Pilgrim Hospital and will span a 2.5-year timescale for completion, bringing us closer to our Net Zero targets.

While overall energy demand remains high, there is a clear trajectory towards improved efficiency and reduced carbon emissions in line with NHS Net Zero ambitions. For further detail, please see the Technical Appendix.

2.15 Financial and environmental impact

Our estates programme is designed to reduce whole-life cost, improve value for money and support delivery of our Green Plan. Investment decisions prioritise patient safety and statutory compliance, then focus on interventions that reduce energy demand, remove high-cost legacy plant and enable more efficient service models, including consolidation and shared use of space. Benefits realisation is tracked through ERIC, Model Health System reports, PAM performance, energy consumption, carbon reporting and delivery of costed action plans.

2.16 Leadership and governance

Strong governance ensures the estate supports safe, high-quality care, value for money and service transformation. Operating under a Group model, LCHS and ULTH are brought together under a single Group Board and Executive Leadership Team, enabling clear strategic direction and strengthened assurance across the acute and community estate. The Group Board holds overall accountability for the ELTDP and receives assurance through the Board Assurance Framework. Scrutiny is provided through the Group's committee structure:

- **Finance and Performance Committee** – oversees capital investment, affordability, prioritisation and estate efficiency.
- **Quality Committee** – provides assurance on patient safety, experience, compliance and quality standards.
- **People Committee** – ensures the estate supports workforce wellbeing, recruitment, retention and modern ways of working.
- **Integration Committee** – oversees how the estate enables service transformation, neighbourhood-based care and partnership working across the health and care system.

Estate governance is aligned with system partners to optimise the use of the public sector estate and ensure infrastructure investment supports the delivery of care closer to home.

Appendix E sets out our Group governance structure.

Lincolnshire Neighbourhood Health and Care Board

The Neighbourhood Health and Care Board enables delivery of neighbourhood-based care by turning strategic priorities into coordinated local action. It brings together system partners to support integrated working and ensure services reflect local needs, while driving the rollout of the National Neighbourhood Health Implementation Programme (NNHIP) across Lincolnshire. See Section 3.2 for more detail on the programme.

For us as a Group, the Board provides a key link between service transformation and estate planning, aligning facilities and investment with neighbourhood models of care and supporting more care closer to home.

2.17 Space management and agile working

Digitally enabled space management and agile working will improve utilisation and reduce unnecessary travel and duplication. The Group is exploring AI-supported allocation and booking systems to make shared spaces easier to manage and use.

Figure 7. Space management and agile working enablers

Enabler	Enabling...	Our approach
Enabling Technologies Programme (network and Wi Fi)	Flexible working, hot-desking, reliable digital access across sites and partner locations	Continue targeted upgrades to improve coverage, resilience and performance, prioritising clinical and high-footfall areas.
Agile working and shared space standards	Higher utilisation of office and meeting space; reduced travel; improved collaboration	Implement clear booking, access and room standards to support consistent use across the Group and with partners
NHS Property Services Open Space platform	Bookable community space; better access to flexible rooms; improved utilisation of shared facilities	Work with NHS Property Services to expand adoption and improve visibility and use of bookable community estate across Lincolnshire

2.18 Capital expenditure and project successes

We are proud of the transformational capital programme delivered in recent years, enabling our vision of *"caring and building a healthier future for all."* Investment has focused on modernising the estate, improving patient outcomes and supporting new models of care.

Recent capital schemes within the estate include:

- New £48m Emergency Department and Urgent Treatment Centre at Pilgrim Hospital.
- A new resuscitation area in the emergency department at Lincoln County Hospital.
- £67m programme for construction of Community Diagnostic Centres in Grantham, Lincoln and Skegness completed 2024 ahead of time and under budget with a further centre underway in Boston scheduled for completion Feb 2027
- A £26.3m endoscopy development and stroke unit expansion at Lincoln County Hospital.
- New modular theatres at Grantham and District Hospital.
- Estates safety and critical infrastructure programmes, including water safety works across sites.
- New staff car park at Pilgrim Hospital.
- Public Sector Decarbonisation Scheme (PSDS) and wider energy efficiency projects to reduce carbon emissions and improve resilience
- Solar Panel installation at Grantham and District Hospital and Lincoln County Hospital.
- Site-wide substation upgrades.
- Site-wide digital fibre upgrades.
- Site-wide lift upgrades.
- New £4m extension of Lincoln Community Diagnostic Centre.
- Catering equipment upgrades.
- Investment in new corporate buildings to increase clinical capacity at Lincoln Hospital.
- New digital data centres
- Significant improvements to our highways, pathways and car parks

We have delivered all completed schemes on time and within budget, demonstrating strong capital delivery capability.

Capital investment is grouped into seven categories:

- **Clinical capacity** – expanding services (e.g. endoscopy, stroke, theatres)
- **Backlog / safety** – addressing high-risk maintenance and compliance
- **Critical infrastructure** – upgrading essential engineering and estates systems
- **Transformational project** – enabling new care models and service reconfiguration
- **Digital enhancements** – improving digital infrastructure and capability
- **Net zero** – decarbonisation schemes including PSDS and energy efficiency
- **General improvements** – smaller works to enhance estate quality.

Together, these categories ensure a balanced approach, addressing safety and infrastructure risks while enabling long-term transformation and sustainability.

Table 2. Five-year capital expenditure as per Group Capital Team report – figures below are exclusive of capital relating to digital and medical equipment upgrades[4].

Type	Total year expenditure 21/22 £'000	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000	Total 5-year expenditure £'000
Clinical capacity	12,574.0	2,531.8	1,991.0	1,754.9	31,467.6	50,319.4
Backlog / safety	2,882.5	977.4	6,720.7	7,747.3	10,128.0	28,456.0
Critical infrastructure	2,719.3	2,564.7	711.4	7,809.8	40,709.6	54,514.8
Transformational projects	2,617.7	16,722.6	23,615.1	49,855.2	2,570.6	95,381.2
Digital Enhancements	-	-	-	1,978.7	6,853.1	8,831.8
Net Zero	227.7	-	121.9	1,376.0	3,569.2	5,294.8
General Improvements	-	-	-	-	49.7	49.7
Total	**21,021.3**	**22,796.5**	**33,160.1**	**70,522.0**	**95,347.8**	**242,847.7**

Capital investment has delivered clear improvements across the estate, including a 75% reduction in waterborne bacteria detections following enhanced water treatment, a 60% reduction in lift breakdowns and an 80% reduction in medical air plant failures.

Upgrades to electrical infrastructure have improved resilience to maintain continuity of supply, while chiller and transformer replacements have enhanced reliability and delivered energy efficiencies. In addition, installation of temporary boiler connection points has strengthened energy centre resilience across acute sites.

[4] ERIC reports £67.5m of public sector funding investment in 2024/25, compared with £70.5m recorded in the Group's capital expenditure records. The variance reflects differences in reporting methodologies and expenditure categories between the national ERIC dataset and the Trust's internal reporting. While the figures are not directly comparable, both demonstrate substantial investment in maintaining, improving and transforming the estate during 2024/25.

2.19 Capital plans

Current capital plans will continue the work of supporting the shift towards community-based, integrated models of care, addressing backlog maintenance and improving estate safety and compliance. Key schemes include:

- Boston Community Diagnostic Centre (CDC)
- Major Acute floor developments at Lincoln County Hospital
- Maternity upgrades at Lincoln County Hospital and Pilgrim Hospital
- Large elective theatre hub at Grantham Hospital
- Skegness Urgent Treatment Centre (UTC)
- Louth Assessment and Admissions Unit (AAU)
- Endoscopy developments
- New stroke facility
- New fire alarm systems at Lincoln and Pilgrim
- Energy efficiency upgrades through Salix fund.
- New acute helipads
- New on-site Lincoln Hospital crèche
- Significant demolition of old buildings.

Future capital investment and funding assumptions are set out in Section 4.3.

2.20 SWOT analysis

The SWOT analysis summarises the key findings from this section, providing a high-level view of our estate position. It highlights the main strengths and weaknesses of the existing estate, as well as the opportunities and threats influencing future estate planning. This synthesis informs the strategic priorities outlined in Section 3

Figure 8. Where are we now SWOT analysis

Strengths	Opportunities	Weaknesses	Threats
• Integrated Group Model enabling aligned planning • Successful capital delivery track record • New CDCs improving flow and patient waiting times • Strong alignment with ICS and national strategy • Established governance and positive PAM areas • Growing energy and sustainability programme	• Estate consolidation and rationalisation • Shift to community-based care 'Left Shift' • Single estate control NHS Property Service transfer potential • Flexible, shared multi-agency spaces • Digital transformation and decarbonisation • Neighbourhood Health Centres / NNHIP rollout • One Public Estate collaboration	• High backlog maintenance and compliance pressures • Ageing infrastructure (M&E, fabric) beyond design life • Fragmented estate and mixed ownership reducing efficiency • Imbalance utilisation (acute overcrowding vs underuse) • High energy intensity in acute estate vs peers	• Escalating backlog risk impacting safety and services • Growing demand from aging population • Rural geography and poor transport access • Environmental factors such as climate change impacting heat, flood and other related risks the estate. • Financial and capital funding constraints • Regulatory and compliance

3. Where do we want to be?

3.1 Overview

This section sets out the national, regional and local drivers informing the Plan and how the estate will support the Group's vision of "caring and building a healthier future for all."

The creation of the new ICB cluster (March 2026), representing Derbyshire, Nottinghamshire and Lincolnshire, brings significant opportunities for the Group. We aim to establish ourselves as a supportive system partner, helping to enable our county health partners to achieve their objectives through shared knowledge and resources. Our ELTDP has been developed in alignment with the ambitions of our system partners and reflects the collective direction of travel across health and care, recognising that many of our strategic objectives can only be delivered through collaboration. Further detail on these regional partnerships, strategies and shared priorities is provided in the Regional Context section below.

To ensure clarity, this framework distinguishes between overarching strategies (formal plans that set long-term objectives), collaborative partnerships (arrangements between organisations) and governance committees (groups responsible for oversight and assurance). Together, these elements shape our estate priorities and inform our decision-making processes.

The estate must adapt to population needs, enable new models of care and support integration across the health and care system. The Plan aligns with the LCHG Group Strategy 2025–2030 and its core ambitions:

- **Providing modern, fit-for-purpose care settings**: Aligning with Group Plan Objective 1d, we are committed to ensuring our care settings are modern, clean and highly accessible. We recognise that fit-for-purpose premises have a significantly positive impact on both patient recovery and staff wellbeing. By 2030, we expect to invest £126.5 million in redevelopment, refurbishment and transformation projects to ensure our sites deliver 21st-century healthcare.
- **Moving appropriate care into community settings**: In line with Group Plan Objective 3a, estate rationalisation and community investment will enable services and resources to move closer to people's homes. This includes expanding the locations, footprint and capabilities of Community Diagnostic Centres and community hubs.
- **Ensuring sustainability and financial viability**: As an Anchor Institution, we recognise our responsibility to safeguard our environment and build resilient communities. Our ELTDP will interlock with LCHG's 2025 Green Plans, ensuring that our buildings and facilities are managed in a way that is both environmentally sustainable and financially viable.
- **Enabling system-wide integration**: The estate must continue to actively facilitate integrated working with our Integrated Care System (ICS) partners, Primary Care Networks and newly established Integrated Neighbourhood Teams. By breaking down organisational silos, our infrastructure will support seamless care delivery.

Ultimately, this ELTDP sets out a definitive plan for a sustainable, innovative, efficient and flexible estate. It aims to reduce backlog maintenance, align with national directives such as the National Neighbourhood Health Implementation Programme and NHSPS Asset Transfer and deliver on the Group's fundamental goals of improving patient care, safety, access and staff experience.

3.2 National context

National context	Guidance intent	What this means for our estate
Fit for the Future: 10 Year Plan for England (2025)	Updated 10-year plan prioritises shifting care into communities, expanding digital innovation, and focusing on prevention to improve outcomes and shape future NHS estate and service models	Our estates will need to shift appropriate services out of acute hospitals into flexible, digitally enabled community settings that support prevention and integrated care closer to home
Naylor Review (2017)	Calls for NHS estates to be modernised, efficiently used, and strategically aligned with financial sustainability and clinical transformation	We must prioritise investment in modern, efficient facilities, reduce backlog maintenance and rationalise surplus estate to release value and support service transformation
NNHIP - National Neighbourhood Health Implementation Programme (2025)	Promotes integrated, community-based care through multidisciplinary neighbourhood teams, improved local access, and coordinated services to reduce hospital demand and enhance long-term health outcomes	Our estate will need to support neighbourhood-based care by developing accessible local hubs and co-located spaces for multidisciplinary teams across primary, community, and social care
Asset Transfers of NHS property - DHSC Guidance (2026)	New DHSC guidance enables NHS Trusts to take ownership of suitable NHSPS estate to strengthen service delivery, improve efficiency, and support long-term integrated care planning	Opportunities to transfer NHSPS assets into a single ownership could enable us to coherently plan our estate, with greater control of our key sites, and improved alignment with clinical service delivery
The Fuller Stocktake Report (2022)	Sets out a model for integrated primary care focused on improving access, strengthening neighbourhood teams, supporting continuity of care, and advancing population health approaches	Our estate configuration will need to enable integration of our county's primary care models, including space for same-day access, multidisciplinary teams, and continuity-focused services within community settings
Delivering a Net Zero NHS (2020)	The NHS is committed to achieving net zero emissions by 2040 (direct) and 2045 (indirect), with organisations expected to reduce environmental impact and support sustainable healthcare delivery	Our estate strategy must prioritise carbon reduction through energy-efficient buildings, electrification, sustainable materials, and rationalisation of underutilised space

National context	Guidance intent	What this means for our estate
Ockenden Review (2022) and AMOS (2026)	Found repeated failures in maternity care, poor clinical practice, care delivery in estate no longer fit for purpose, inadequate investigations, and a culture that did not listen to women and families leading to avoidable harm and deaths. It recommends urgent national improvements in safety, accountability, staffing, training and leadership, across maternity services in England	Our estate must support safe, high-quality maternity care through appropriate capacity, modern clinical environments, effective adjacencies, and infrastructure that enables improved patient safety, staff wellbeing, privacy, and family-centred care
Carter Report (2016)	Highlights opportunities to improve NHS productivity by reducing estate waste, optimising space use, and benchmarking performance	A continued focus on improving space utilisation, reducing non-clinical footprint, and driving productivity gains across the hospital estate
Model Health System (2020)	This tool enables NHS organisations to benchmark estate performance and identify improvements in utilisation, cost efficiency, and energy consumption	Benchmarking our data will guide estate decisions locally, helping identify inefficiencies and opportunities for us to improve utilisation, cost performance, and energy use
Terrorism (Protection of Premises) Act (2025) / Martyn's Law	Requires NHS premises to implement proportionate security measures and preparedness plans to protect against terrorist threats	Continuing to upgrade our sites to incorporate proportionate security design, risk assessments, and operational protocols to enhance safety and resilience for patients, staff, and visitors
SMART / Intelligent Hospitals	SMART hospitals integrate digital infrastructure and intelligent systems to enhance patient care, operational efficiency, flexibility, and sustainability	Investment will be required in our digital infrastructure and smart building systems to support data-driven care, automation, and more efficient, responsive estate operations
Modern Methods of Construction (MMC)	Supports faster, more efficient healthcare building through modular and prefabricated construction techniques	Continuing our use of MMC will enable faster delivery of new clinical facilities and upgrades across the county, supporting service reconfiguration with reduced disruption and cost

3.3 Regional context

Better Lives Lincolnshire – Integrated Care Partnership Strategy 2024

The Integrated Care Partnership Strategy 2024) sets the system-wide ambition to improve health and wellbeing across Lincolnshire, with a focus on prevention, reducing inequalities and delivering more integrated, community-based care.

Figure 9. Better Lives Lincolnshire – Integrated Care Partnership Plan priorities and enablers

Priorities (What)		Enablers (How)	
• Mental health and dementia	• Home for independence	• Prevention	• Personalisation
• Dementia	• Carers	• Inequalities	• Digital and technology
• Healthy weight	• Physical activity	• Workforce and skills	• Data and intelligence

For us, this reinforces the need for an estate that enables care closer to home, supports partnership working and provides flexible, digitally enabled facilities.

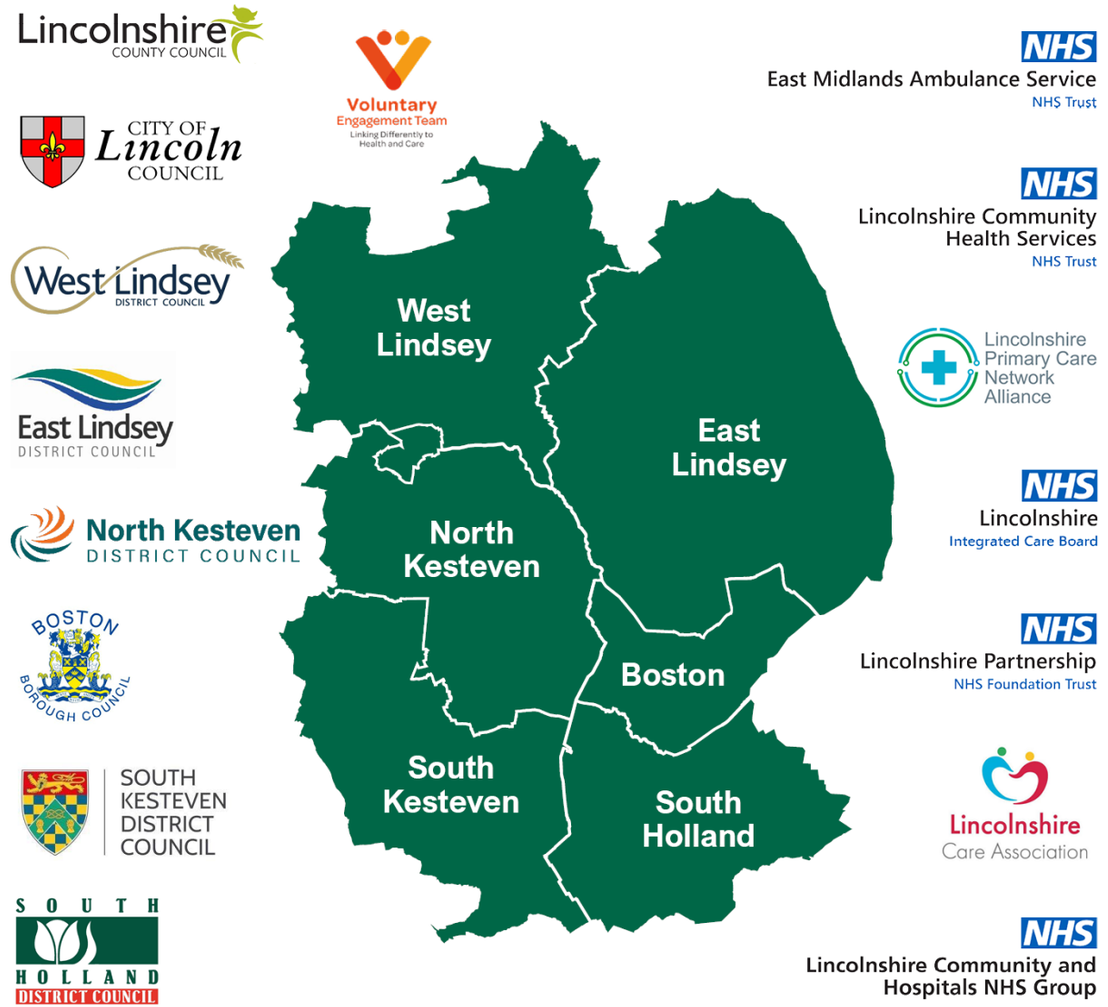
NHS ICB Lincolnshire Infrastructure Strategy 2024-34

The NHS ICB Lincolnshire Infrastructure Strategy 2024–34 aligns closely with the Better Lives Lincolnshire Integrated Care Partnership Strategy, providing the physical and digital infrastructure required to deliver its priorities around prevention, reducing inequalities and integrated neighbourhood care, particularly through the development of community hubs and improved estate utilisation. Its vision is to develop safe, sustainable and flexible infrastructure that enables the right care to be delivered in the right place, with a strong emphasis on shifting care into community settings and improving access in rural and coastal areas.

DLN ICB 5-Year Strategic Commissioning Plan 2026/2031

The Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire (DLN) region faces significant health inequalities, deprivation, poorer health outcomes, an ageing population, and rising demand for services. The plan aims to transform care through integrated neighbourhood services, increased delivery closer to home, digital innovation, and a coordinated estates approach that supports modern, efficient, and sustainable healthcare.

Figure 10. Lincolnshire ICS map and partners



Key priorities include modernising ageing estate, developing integrated community hubs, improving utilisation of existing assets and embedding digital capability to support new

models of care and reduce reliance on acute sites. For LCHG, this provides a clear direction to:

- invest in community and neighbourhood infrastructure
- enable integrated, multi-agency service delivery
- support estate consolidation and efficiency
- align estate planning with population health needs and system transformation.

The following schemes represent the ICB's immediate priorities and longer-term transformational programmes, all of which have implications for the future LCHG estate where funding has not yet been identified:

Figure 11. Lincolnshire ICB immediate priorities that link with LCHG future estate

Enabling left shift	Design a multi-service facility delivering integrated primary and community care, focused on prevention, local health needs, and reducing inequalities
Critical infrastructure development	Optimisation of systems to support a more resilient estate, reduce backlog maintenance, improve safety and enable better care
Cyber security technical controls, training, business continuity measures	Protects critical systems from cyber threats and ensures rapid recovery to maintain safe, uninterrupted care
Lincoln maternity improvements	Development of a more modern and fit for purpose building - reducing backlog maintenance, improving patient safety, enabling better care and compliance with CDC notices around theatres and ventilation
Run and Develop Lincolnshire Care Record	Enables integrated care through shared data across Lincolnshire, improving outcomes, reducing duplication, and supporting better decision-making. Ongoing investment needed to maintain and expand system-wide data sharing

Figure 12. Lincolnshire ICB transformational schemes that link with LCHG future estate

Trust-wide theatre strategy and redevelopment	Develop modern, fit-for-purpose theatres to improve patient safety, reduce backlog maintenance, and ensure regulatory compliance around theatres and ventilation
Cancer Centre	Develop a modern, purpose-built cancer centre to manage demand, improve patient safety, reduce backlog, and ensure regulation compliance
Stroke ASR upgrade	Develop a modern, expanded stroke centre to increase capacity, improve patient safety, reduce backlog, and ensure compliance
Skegness Hospital **Gainsborough Hospital** **Louth Hospital** **Johnson Community Hospital**	Invest in community hospitals especially in rural areas and renewal programme for Skegness area, to deliver more care closer to home, increase capacity, and reduce health inequalities. Review estate across Urgent and Emergency Care, inpatient and outpatient care to align with clinical strategy
Support developing Community Primary Partnerships	Use digital solutions to enable Community Primary Partnerships, supporting modern care and efficient use of resources
Lincoln South-East Quadrant Hub	Develop an integrated care hub to support population growth, expand capacity, and enable co-located PCN, community, and voluntary services
Wearable technology to support prevention or early intervention	Use digital and technology to transform care, manage resources and demand, as well as to support prevention and care closer to home
Neighbourhood centres	Anchor integrated health and social services within communities, ensuring residents receive personalized, proactive, and accessible care right on their doorstep

One Public Estate (OPE) Programme

The Greater Lincolnshire One Public Estate (OPE) programme brings together over 40 public sector partners to maximise the value and use of public assets, enabling service integration, regeneration and more efficient estate use. Through collaboration with local authorities and system partners, we can support co-location of services, development of integrated hubs and release of surplus land to drive housing and economic growth.

The programme aligns closely with our ambition to deliver neighbourhood-based care, improve access and rationalise the estate while reducing running costs and enabling reinvestment into modern, fit-for-purpose facilities.

Key principles

- Collaboration across public sector partners
- Optimising use of the public estate portfolio
- Supporting integrated, place-based service delivery
- Releasing value from surplus or underutilised assets
- Aligning estate decisions with population and system needs
- Driving financial sustainability and efficiency
- Enabling regeneration and wider social value

Key benefits

- Co-location of health, local authority and partner services
- Development of integrated community and neighbourhood hubs
- Release of surplus land to support housing and regeneration
- Reduced running costs across the public estate
- Improved accessibility and services closer to home
- Better utilisation of existing assets and estate consolidation
- Increased opportunities for capital receipts and reinvestment

Partnering with Primary Care in Lincolnshire

Primary Care Networks (PCNs) are key partners in delivering integrated, neighbourhood-based care across Lincolnshire. The county's 14 PCNs provide an established framework for planning services around local population needs and reducing health inequalities. Figure 13 illustrates the geographic distribution of PCNs across Lincolnshire, supporting coordinated service delivery across urban, rural and coastal communities.

Figure 13. Lincolnshire Primary Care Network geography



This partnership will help improve access to care, reduce unnecessary travel, strengthen multidisciplinary working and ensure estate investment is aligned to local population needs.

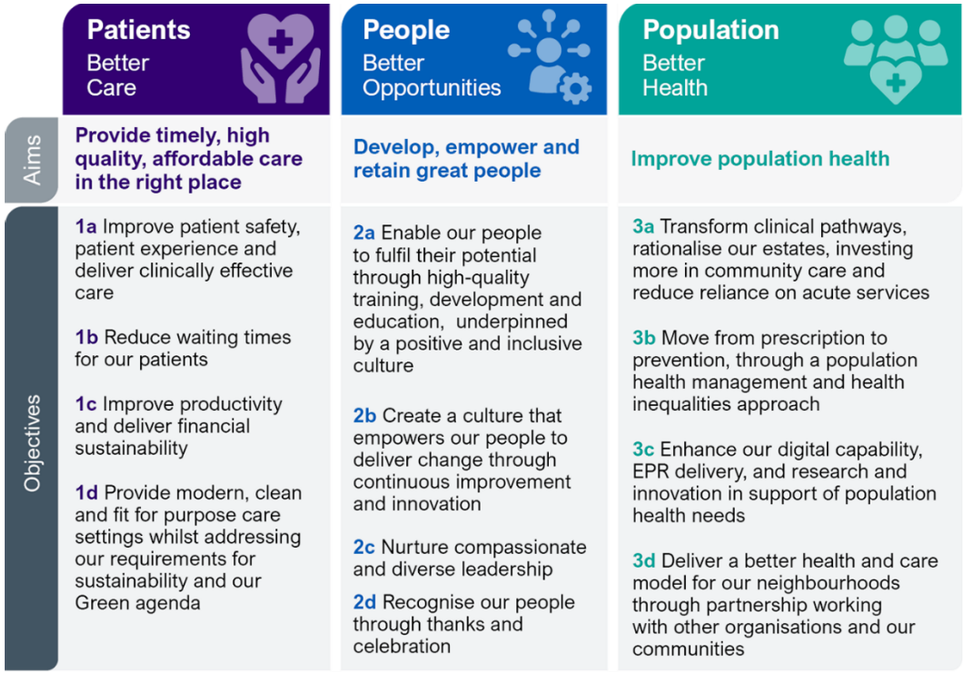
By working collectively across primary, community and acute care, we can create a more integrated, accessible and sustainable healthcare system for Lincolnshire

3.4 Local drivers for change

LCH Group Strategy

The LCHG Group Strategy 2025–2030 is the partnership plan between ULTH and LCHS that sets out our ambition to deliver better care, improve population health and create a more supportive environment for staff. Built around our vision of "***caring and building a healthier future for all***", the plan places a strong emphasis on integration across acute, community and primary care services, supported by close working with system partners.

Figure 14. Strategic aims and objectives



It responds to the challenges of an ageing and dispersed population by focusing on improving access, reducing inequalities and making better use of resources. Central to this is a commitment to change how care is delivered, with greater use of digital solutions, prevention and more coordinated pathways that better meet local needs.

A key element of the plan is the shift towards delivering more care outside of traditional hospital settings. This 'Left Shift' approach seeks to move activity into community and neighbourhood-based services, supporting earlier intervention and reducing reliance on acute care. For the estate, this means a gradual rebalancing of the portfolio: modernising core hospital sites while strengthening the role of community facilities. The estate will need to support more flexible, multi-use environments, enabling services to be delivered closer to home and in partnership with other organisations. It also requires a sharper focus on efficiency and utilisation, ensuring space is used effectively and aligned with changing service models, alongside continued investment to provide modern, safe and sustainable facilities for patients and staff.

Clinical Service Strategy

Our Clinical Services Strategy sets out how we will reshape services over the period 2026-2031 to support delivery of our Group ambitions. It continues the focus on moving care closer to home, reducing reliance on acute hospitals for non-urgent care, allowing those sites to be reframed as specialised acute and emergency sites, and strengthening integrated neighbourhood models, supported by digital and innovative approaches to care delivery.

For our estate, this translates into a more distributed model, with increased use of community hubs, diagnostic centres and virtual care, alongside modernised acute sites focused on specialist and complex activity. Our estate will need to be more flexible, support integrated working and enable new models of care across community and hospital settings.

Figure 15 demonstrates how redesigned pathways will shift demand away from acute hospitals and increase activity in community settings, reinforcing the need for more flexible, community-focused estate provision.

Figure 15. Collaborative operating model

	Now	Action	Measures
Unplanned Care	Disruption	Attendance avoidance Admission avoidance LOS reduction Urgent care in primary care	Bed days reduction
Planned Care	Integrated Neighbourhood Teams Long term conditions management *Left Shift* into the community	Long term conditions OPDs with GPs CDCs/diagnostics Risk stratification of primary care Complex case management with integrated neighbourhood teams	Reduced primary care demand Increased community care demand More days in your own beds
Resilient Communities - Self Care	Service for residents Prevention	Social determinants of health Co-ordinate public sector directory of prevention services	Less demand in acute by pathway Reduced unnecessary demand on primary care

Green Plan Strategy

Our Green Plan Strategy (2025–2028) sets out a coordinated programme of estates-led action to reduce carbon emissions, improve resource efficiency and strengthen climate resilience across our acute and community estate.

The approach follows three key principles: reducing demand through improved building performance and space utilisation; decarbonising energy supply; and reducing wider emissions through service change, travel and waste. Alongside this, we are improving biodiversity and integrating water efficiency into maintenance and capital programmes.

While delivered at a Group level, priorities differ across the two organisations. ULTH focuses on decarbonising large, energy-intensive acute sites and reducing emissions from clinical activity. LCHS places greater emphasis on enabling community-based care, reducing travel across a rural geography and improving the efficiency of a largely leased estate.

Sustainability is closely linked to clinical transformation and digital enablement, supporting reduced travel, more local care delivery and lower-energy ways of working. Together, these measures position the estate as a key enabler of a low-carbon, resilient and future-ready healthcare system.

One Digital Strategy

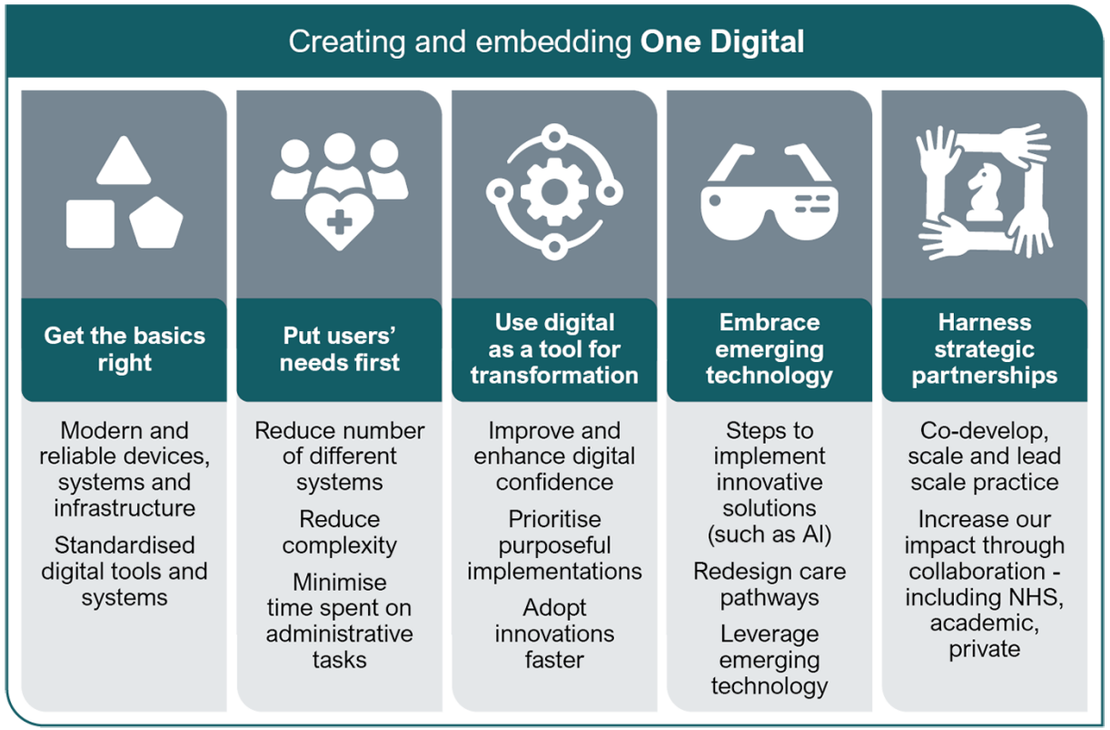
Our One Digital Strategy (2025–2028) sets out a unified approach to digital transformation across both LCHS and ULTH, recognising digital as a critical enabler of safe, high-quality and sustainable care. The plan brings together previously separate digital programmes under a single framework, enabling greater scale, consistency and pace of delivery across the organisation.

We will ensure the estate across Lincolnshire provides consistent, resilient digital infrastructure and standardised systems, enabling staff to access the same tools and information regardless of location. Given the county's rural and dispersed nature, this will place a stronger emphasis on creating well-connected, digitally enabled environments that support remote consultations, mobile working and closer integration between sites. In turn, the estate will increasingly prioritise flexibility, reduce reliance on traditional service models and better support the shift towards delivering care closer to home.

Theatre Strategy

We aim to modernise and future-proof ULTH's operating theatres, addressing ageing infrastructure and current Health Building Note (HBN) and Health Technical Memorandum (HTM) non-compliance. We want to create safe, efficient, modern environments that improve productivity, reduce cancellations, and enhance patient experience and care quality. We are using infrastructure assessments, workforce modelling, and demand-and-capacity planning across elective and trauma pathways, while optimising clinical adjacencies and aligning with the Trust's clinical strategy. We propose Grantham as a hub for high-volume, low-complexity elective surgery, with planned growth over 15 years, with the aim to become a Centre of Excellence in this area.

Figure 16. One Digital Strategy



The programme will be delivered in phases to maintain continuity of elective and emergency services. LCHG will continue to support the East Midlands Orthopaedic Centre (EMOC) at Grantham Hospital, maximising the use of existing estate capacity while generating valuable income for the Group. This supports Grantham's role as a specialist elective hub and contributes to the long-term sustainability of the estate.

(1) 3.5 Implications for the Plan

The national, regional and local drivers inform the strategic objectives below, which will guide estate investment, prioritisation and delivery throughout the Plan.

Figure 17. Group Estates Long Term Delivery Plan strategic objectives

Enable integrated neighbourhood care

- Work collaboratively with partnerships organisations including LPFT, Primary Care Networks, neighbouring trusts and local authorities to implement a robust and fit for purpose Left Shift
- This includes delivering services closer to residents through neighbourhood-based models of care and working with public sector partners to improve access, reduce travel and address health inequalities
- Through a One Public Estate approach, we will maximise the value and impact of public sector assets by supporting co-location, shared facilities and integrated service delivery, helping to improve access and strengthen communities
- Progress the NHSPS asset transfer programme to secure greater control over property management, community estate optimisation and future investment across our portfolio

SO1

Optimise and rationalise our acute estate

- As more services move into the community, we will consolidate and modernise our acute estate to support safe, efficient and patient-centred care, while ensuring specialist, complex and emergency services remain in high-quality acute settings
- This will be supported through estate optimisation, digital infrastructure and data-led planning, improving efficiency, reducing backlog risk and enabling future models of care
- We will identify surplus assets and disposal opportunities to support financial sustainability while developing modern, adaptable facilities fit for the future

SO2

Improve adjacencies and service flow across both acute and community sites

- Improve adjacencies and service flow across acute and community sites to support safe, efficient and patient-centred care
- Strengthen the integration of key clinical services, including maternity and surgery, to streamline pathways and improve outcomes
- Optimise and redesign the acute estate as care shifts into the community, making better use of space and supporting admission avoidance, specialist care and seamless patient pathways
- Review corporate and administrative facilities to maximise efficiency, enable modern ways of working and free up capacity for patient care

SO3

Improve patient and staff experience through a sustainable, accessible and future-ready Group estate

- Reduce backlog maintenance risk and improve estate safety, resilience and compliance
- Ensure facilities are accessible, modern and fit for purpose, supporting staff wellbeing, patient experience and clinical productivity
- Increase utilisation of flexible, shared and digitally enabled workspaces, including collaborative office space and MDT environments
- Invest in digital infrastructure and smart technologies to support new ways of working and improve operational efficiency
- Reduce carbon emissions and improve energy efficiency through sustainable building design, estate modernisation and Net Zero initiatives

SO4

Enabling and supporting priorities – opportunity register

Optimising the community estate

The optimisation of our community estate is central to delivering neighbourhood-based models of care across Lincolnshire. By moving to a fully digitally enabled system and expanding virtual service provision, we can shift appropriate activity away from acute sites into community settings and people's homes. This approach will also help us make better use of our community assets. This will involve the rationalisation and repurposing of our estate, alongside improvements in how sites are managed and utilised to support service delivery.

Benefits

- Improves access to care closer to home and reduces unnecessary travel to the acute site.
- Reduces pressure on the acute estate and supports more integrated, preventative models of care.
- Improves utilisation of community assets and delivers better value for money.
- Reduces ongoing revenue and energy costs through rationalisation and proactive estate management.
- Closes the gap around health inequalities in our harder to reach areas.

Space utilisation

We will review our non-clinical and clinical spaces across the portfolio and maximise opportunities to consolidate and rationalise zones that are underutilised and outdated. We will also continue to improve our booking systems to give a clear picture of usage and make spaces more accessible to staff and services. We will also commit to improving signage and wayfinding across our sites following patient feedback.

Benefits

- Improved efficiency of utilisation, including better access to needed multi-disciplinary team spaces for staff.
- Creates better flow and more accessible estate for patient, staff and visitors.
- More robust booking system allows for SMART hospital technology and soft FM services such as cleaning to power and access rooms in an efficient cost-effective way.
- Greater flexibility in service delivery.

Improving acute clinical adjacencies and flow

On the acute sites, we will focus on remodelling clinical service delivery to improve adjacencies, reduce fragmentation and support modern, efficient care pathways. To achieve this, we must consolidate outpatient care, assessment and diagnostic functions off site where appropriate, strengthening links between key acute services and addressing inefficiencies created by improving site flows. Our initial focus will be maternity, elective theatres, emergency care and acute care.

Benefits

- Improves patient flow and reduces delays and bottlenecks across priority pathways.
- Enhances operational efficiency and staff productivity.
- Supports same-day and streamlined pathways, improving patient experience.
- Allows for a more efficient and holistic approach to care.
- Improves value for money across a streamlined way of working.
- Creates more resilient and flexible clinical footprints to respond to changing demand.

3.5 Engagement

The Plan has been informed by site visits, discussions with colleagues, Clinical Cabinet meetings and three thematic workshops. The workshops considered the estate implications of moving care closer to home, opportunities to improve acute site efficiency, and enabling requirements across finance, procurement, HR, environmental services and estates.

Wider patient feedback has also informed estate priorities. Patient groups will remain involved as individual projects develop to ensure proposals meet the needs of patients, staff and visitors.

Notes from the workshops can be found in Appendix F.

Figure 18. Stakeholder workshop findings informing the Plan, May–June 2026



4. How do we get there?

4.1 Strategic options

Acute estate optimisation

The acute estate will continue to play a critical role within the Group's future operating model. Whilst appropriate services will continue to move into community and neighbourhood settings, Lincoln County Hospital, Pilgrim Hospital and Grantham and District Hospital will remain at the centre of specialist, emergency, elective and inpatient care across Lincolnshire.

Engagement undertaken as part of this ELTDP identified a clear ambition to improve patient flow, strengthen clinical adjacencies and ensure the estate supports modern models of care. Priorities across the Group include reducing pressure on acute sites through the delivery of more care closer to home, improving discharge and patient flow, increasing flexibility within the estate and modernising facilities to meet current HBN and HTM standards. Digital technologies, AI and advanced diagnostics will play an important role in supporting these ambitions.

A two-year Flow Transformation Programme is already underway, aligned to the NHS 10-Year Plan. The programme focuses on improving acute flow, increasing community capacity and supporting admission avoidance. Initial work is focused on reducing length of stay and improving patient journeys through the acute bed base, creating capacity and supporting more efficient use of the estate.

Recognising the different roles of each hospital, a site-specific approach will be taken to acute estate transformation.

Lincoln County Hospital – Acute Care Transformation

As the Group's principal acute hospital, Lincoln County Hospital will be the pilot site for a new acute care model. This will focus on the development of an integrated acute floor, bringing together key services and multidisciplinary teams to improve patient flow and support more timely assessment, treatment and discharge.

Estate priorities include improving clinical adjacencies, strengthening renal provision, enhancing theatre compliance and creating a more efficient site layout. Opportunities will also be explored to relocate appropriate non-clinical functions away from the core hospital site, releasing space for clinical activity. The development of a new on-site helipad, as part of the wider acute floor transformation programme, will improve access for air ambulance and support faster access to critical and specialist services. Lessons learned through the programme will help shape future developments across the Group.

Pilgrim Hospital, Boston – Acute and Emergency Care Development

Building on recent investment in the Emergency Department and Urgent Treatment Centre, Pilgrim Hospital will continue to strengthen its role as a major acute hospital serving the rural and coastal communities of South and East Lincolnshire.

Future priorities include expanding same-day emergency care and ambulatory pathways, improving clinical adjacencies and supporting better patient flow. Planned investment in maternity services, infrastructure and site access will help address existing constraints, improve resilience and support future service growth. The upgraded on-site helipad will further strengthen the hospital's role as a major acute and emergency care site, improving access to specialist services, supporting faster transfers for critically ill and injured patients, and reducing the need for trauma patients to travel further afield for treatment.

Grantham District Hospital – Elective and rehabilitation hub

Grantham and District Hospital will continue to develop its role as the Group's elective and rehabilitation hub. Building on recent investment in theatres and supporting infrastructure, the hospital will accommodate increased levels of planned care activity, including opportunities to expand services such as orthopaedics and ophthalmology.

Concentrating elective activity at Grantham will improve productivity, reduce cancellations and support the separation of elective and emergency pathways. The hospital will also continue to support specialist programmes, including the East Midlands Orthopaedic Centre (EMOC), strengthening its contribution to the wider health system.

Cross-site priorities – Enabling system-wide improvement

Across all three acute sites, a coordinated programme of improvement will support delivery of this model, including:

- **Maternity upgrades**, ensuring safe, modern and resilient facilities
- **Theatre modernisation**, aligned with the elective hub model

- **Improved clinical adjacencies and patient flow**, reducing fragmentation and inefficiencies
- **Digital enablement**, supporting real-time decision-making and integrated care pathways
- **Targeted investment in backlog and critical infrastructure** to improve estate resilience.

Community and neighbourhood estate

Work is underway to identify services suitable for delivery outside acute hospitals. Data modelling will map these services against evidence-based patient pathways to inform community provision. The ambition is to halve the approximately 16 million miles patients currently travel each year for outpatient appointments by providing more diagnostic, outpatient and ambulatory care in neighbourhood settings.

Our new neighbourhood board is working to identify locations for new neighbourhood care centres to best serve our populations health needs. We recognise that no single solution will meet all required service needs so close partnership working across a One Public Estate model, which utilises estate buildings from NHSPS, local authorities and our partner organisations, will provide much needed opportunity for executing this new and exciting model of service delivery.

NHSPS asset transfer

Department of Health and Social Care (DHSC) guidance published on 29 January 2026 introduces a voluntary process for NHS Trusts to request the transfer of eligible NHSPS-owned and leased assets through ICB-led coordination. The policy aims to strengthen local decision-making, support integrated neighbourhood care models and improve productivity by enabling provider ownership of key “core” community estate assets. The successful transfer of the assets would also allow for a more streamlined and equally distributed capital investment process across all our key acute and community assets, giving us the opportunity to continue to invest in modernising our acute sites but also critically bring our community estate to an equal standard of compliance and ready for the transfer of patient activity.

We will work with the ICB and partners to explore transfer of asset ownership and partnership management of selected community sites to better support pathways, reduce estate-related barriers and align investment to system priorities. Early actions include confirming which sites are strategically relevant, validating the NHSPS “core” list and obtaining baseline property information to assess affordability, compliance and risk. If progressed, formal business cases would be developed, with potential transfers from late 2026 subject to due diligence, affordability and approvals.

*Table 3. NHSPS properties (*at February 2026)*

NHSPS property code	Property Name	Type	Core or Flex property *
10004635	Crowland Health Clinic	Health Centre / Surgery / Clinic	Flex (confirmed)
10005569	John Coupland Hospital	Hospital	Core (confirmed)
10005576	Johnson Community Hospital PFI	Hospital	Core (confirmed)
10004539	Louth Site Block 31	Hospital	Core (confirmed)
10009453	Louth Site Block 45	Hospital	Core (confirmed)
10009355	Richmond Medical Practice	Health Centre / Surgery / Clinic	Core (confirmed)
10010013	Saxilby Health Centre	Health Centre / Surgery / Clinic	Core (confirmed)
10009975	Skegness Day Centre	Day centre	Core (confirmed)
10004299	Boston Health Centre	Health Centre / Surgery / Clinic	Flex
10007626	Fen House	Office	Flex
10005175	Grantham Health Centre	Health Centre / Surgery / Clinic	Flex
10010175	John Coupland Hospital (Scotter Ward)	Hospital	Core
10009773	Louth County Hospital Antennae Mast	Hospital	Core
10004520	Louth site blocks (Multiple)	Hospital	Core
10006611	Pottergate Health Centre	Health Centre / Surgery / Clinic	Flex
10007086	Skegness Hospital	Hospital	Core (Confirmed)
10004946	Unit 15	Office	Flex

NOTE. Louth blocks include: 1, 5-8, 10, 11, 13-23, 27, 33 and 42-44.

NOTE. *Categorised by NHSPS based on strategic importance and utilisation:* ***Core*** *= essential long-term assets;* ***Flex*** *= may be retained or repurposed;* ***Tail*** *= lower-priority assets for potential disposal (Tail properties excluded from transfer).*

Mobile clinics

Further to the proposed neighbourhood care centres, there are currently mobile services which provide breast screening and retinal screening to rural and coastal communities. A potential expansion of mobile services could be explored with the aim of bringing health and services directly into communities.

This approach aims to improve access, prevention and early intervention by engaging people who face barriers to traditional services, thus reducing health inequalities and preventing escalation to more acute care.

4.2 Project sequencing, phasing and design

Development Control Plans

This ELTDP is an evolving document that establishes a long-term framework for development across Lincolnshire's key sites over the next 10 years. It will be regularly reviewed and adapted in response to changing clinical priorities, infrastructure requirements and organisational needs. The plan also informs our Development Control Plans for 2026–27. Development control plans are provided in Appendix C.

4.3 Funding and resourcing

Group capital investment and allocations

The capital programme will prioritise backlog reduction and estate modernisation according to risk. Despite recent investment, ageing infrastructure and critical engineering systems remain significant pressures. Funding assumptions are based on the capital allocations shown in Table 4 for 2026/27–2029/30. The proposed Pilgrim Hospital maternity redevelopment is not included in those allocations.

Salix grant funding supports energy efficiency and decarbonisation schemes that reduce emissions and long-term operating costs. Capital headroom is also influenced by system financial performance: delivery of the system revenue plan generates a one-off, in-year system bonus, while non-delivery reduces future capital flexibility.

Table 4. LCHG capital allocations summary, 2026/27–2029/30

	Group total				
	26/27 £'000	27/28 £'000	28/29 £'000	29/30 £'000	**TOTAL £'000**
Revised operational capital allocation	**31,887**	**31,619**	**33,010**	**33,521**	**130,036**
Estate Safety Fund					
Estates Safety Target Maintenance	5,269	3,663	0	0	**8,932**
Estates Safety: Strategic - LCH Maternity	1,000	10,000	18,000	19,000	**48,000**
Estates Safety: Strategic - PHB Maternity	0	0	0	0	**0**
Estates Safety: Strategic - GDH Theatres	0	0	0	1,000	**1,000**
Return to Constitutional Standards					
Diagnostics Schemes	17,730	0	0	1,020	**18,750**
UEC Schemes	7,000	5,750	6,250	4,750	**23,750**
Community Schemes	1,750	2,500	1,000	1,000	**6,250**
Total allocations	***64,636***	***53,532***	***57,260***	***60,291***	***235,718***
Other resource: Salix Grant	10,493	10,493	0	0	**20,986**
Sub-total	***75,129***	***64,025***	***57,260***	***60,291***	***256,704***
Fair Shares / System Bonus	10,313	0	0	0	**10,313**
Total Resources - excluding disposals	***85,442***	***64,025***	***57,260***	***60,291***	***267,017***
Implementation: ICT Infrastructure	-153	-31	0	0	**-184**
Planned disposals / Tfrs: ICT Infrastructure	606	978	0	0	**1,584**
Total Resources - inc disposals	***85,895***	***64,972***	***57,260***	***60,291***	***269,418***

Financial reconciliation required: Table 4 retains the source figures. Its final annual values total £268.418m, compared with the stated £269.418m total, a difference of £1.000m. The total and underlying allocations require confirmation before publication.

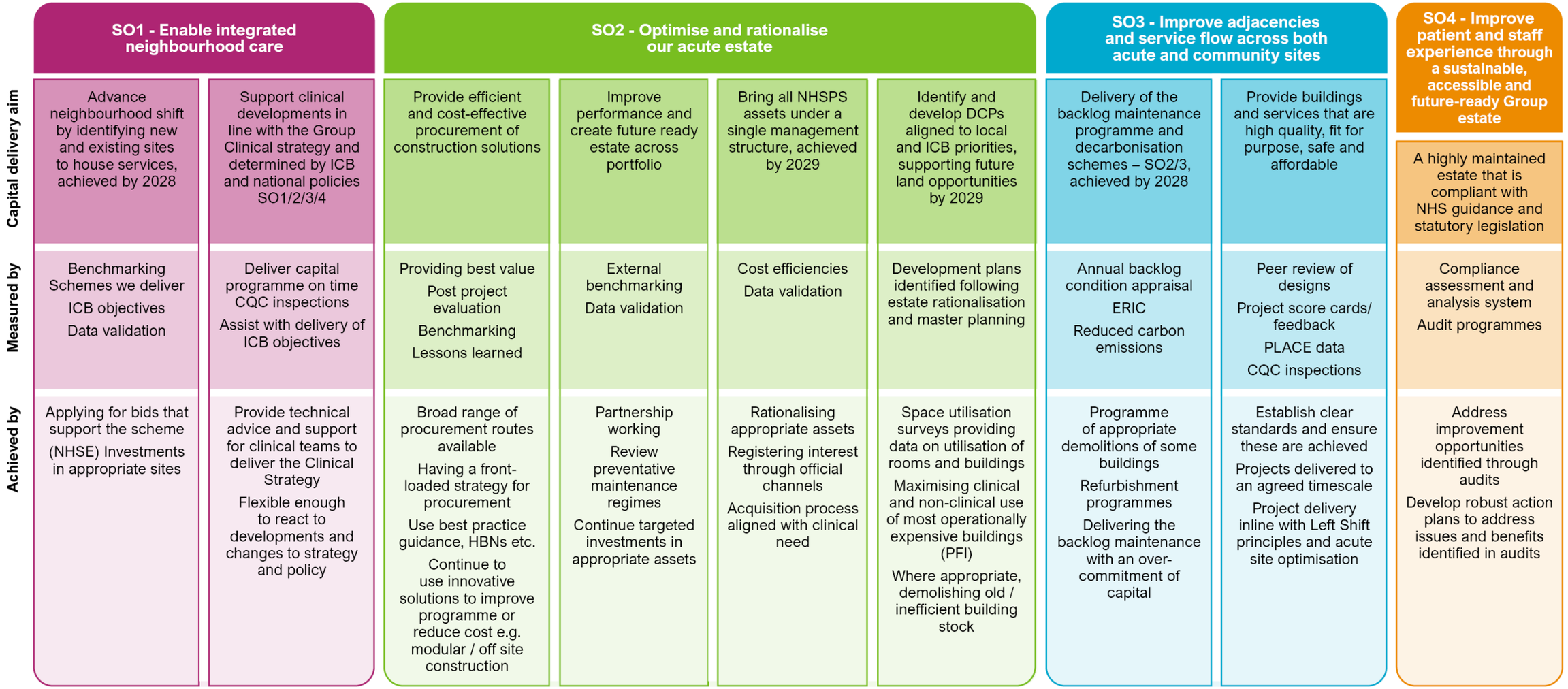
Main areas of investment include:

- Estates safety, including fire alarms, electrical systems and related works
- Diagnostics (Boston CDC development)
- UEC upgrades, including SDEC and acute floor redesign
- Strategic schemes (maternity, theatres).

Looking beyond 2026/27, capital allocations will continue to be shaped by national planning frameworks and funding mechanisms. Allocations are increasingly linked to both the scale of the asset base (through depreciation) and the level of critical infrastructure risk, reinforcing the need for robust asset management and prioritisation. While targeted estates safety funding will support elements of backlog reduction, this remains significantly below the total requirement, necessitating a long-term, phased approach to backlog eradication.

4.4 Estate capital and development roadmap

Figure 17. Roadmap



4.5 Governance

The Plan will be delivered through defined programme structures and the established approval, reporting and assurance arrangements described in Section 2.16. These arrangements will maintain alignment with strategic priorities, control risk and support timely decisions. The Lincolnshire Neighbourhood Health and Care Board will coordinate local priorities, align investment and resolve cross-partner dependencies, ensuring estate decisions support service design and population needs.

Our group's governance structure can be found at Appendix E.

4.6 Sustainability and Net Zero

We recognise that our estate is a significant contributor to carbon emissions, operational costs and climate risk, but also a critical enabler of safer, more resilient and sustainable models of care across a large and predominantly rural geography. The ELTDP therefore aligns directly with the LCHS and ULTH Green Plans, ensuring that carbon reduction, climate resilience and environmental performance are embedded alongside backlog reduction, service transformation and financial sustainability.

We are committed to achieving Net Zero carbon emissions for those emissions we directly control by 2040, in line with national NHS targets, while supporting the wider NHS ambition for Net Zero Carbon Footprint Plus by 2045. For the estate this requires a pragmatic, phased approach that reflects the diversity of the asset base, including large acute hospital sites, community hospitals, health centres and a substantial proportion of leased accommodation. Sustainability will be addressed through a combination of demand reduction, decarbonisation of energy supply and service configuration that reduces reliance on the physical estate.

Climate resilience is a core consideration for the Lincolnshire estate. We will ensure that buildings, infrastructure, vehicles and supporting supply chains are increasingly resilient to the impacts of climate change, including heatwaves, flooding and extreme weather events.

Work is currently well underway to map our current carbon baseline and 5-year reduction plan, which will be supported by a Group Climate Change Adaptation Plan and by integrating resilience measures into new developments, refurbishments and major plant replacement, ensuring continuity of services and protection of patient and staff safety.

Green Plan actions

The LCHG Green Plans for 2025-2028 set out a focused programme of estate-led actions aimed at reducing carbon emissions, improving environmental performance and strengthening resilience across acute and community sites. Key estate-focused actions include:

Energy and carbon reduction

- Improving building fabric, controls and energy management systems to reduce demand
- Delivering phased heat decarbonisation, prioritisation sites with ageing plant and high energy use
- Increasing the use of low-carbon and renewable energy where feasible.
- Continuing the transition over to electric vehicles (EV), including fleet vehicles, pool cars and ambulances in line with national plans with the EV infrastructure to support.

Climate adaption and resilience

- Designing new buildings to mitigate overheating and flood risk
- Adapting existing buildings where practicable to improve resilience of critical infrastructure
- Aligning estate investment with emergency preparedness and business continuity planning.

Water, waste and biodiversity

- Investigate and address rising water consumption by refreshing reduction targets, building on the work to introduce copper-silver ionised water systems across our sites to significantly reduce flushing requirements for legionella control.
- Improving waste segregation and reducing high carbon waste streams
- Enhancing biodiversity through proportionate landscaping approaches that reduce green-waste and fuel use
- To meet Biodiversity Net Gain (BNG) requirements by delivering at least a 10% uplift across new developments, prioritising avoidance, minimisation, restoration and offsetting where necessary. A clear BNG objective will help reduce project delays and costs, while supporting our Green Plans.

Supporting sustainable models of care

- Enabling service changes that reduce patient and staff travel, including community-based care, virtual wards and virtual clinicals
- Supporting more consolidated pathways, such as single-visit assessment models, to reduce repeat hospital attendance.

Green Plan governance

Delivery of sustainability and Net Zero commitments is governed at Group level, aligning the ELTDP with ULTH and LCHS Green Plans and wider priorities. Estates and Facilities lead delivery and performance, supported by clinical, operational and digital teams where required.

Progress is tracked through internal governance and national frameworks (ERIC, PAM), with the ELTDP providing the long-term framework to embed sustainability across estate configuration, capital investment and service transformation.

4.7 Risk management and liability

We adopt an integrated approach to risk management, ensuring estate risks are identified, assessed and managed through established governance processes. Significant estate risks are reflected within organisational risk registers and, where appropriate, escalated to the Board Assurance Framework, providing Board oversight of the key risks that could affect the delivery of strategic objectives.

The principal estate risks across both organisations relate to fire safety compliance, ventilation and environmental standards, and the challenges associated with an ageing estate. These risks have the potential to affect patient and staff safety, service delivery and regulatory compliance. To manage them, a range of controls are in place, including compliance audits, risk assessments, staff training, monitoring programmes and regular governance review.

Targeted capital investment and improvement programmes are being prioritised to address these risks, particularly those relating to fire safety, ventilation infrastructure and estate modernisation. This investment will support the delivery of safe, compliant and sustainable services while reducing risk exposure over time.

5. Conclusion and next steps

5.1 Future strategic intent

The Plan establishes the estate delivery framework for 2026–2036. It builds on completed investment while addressing significant backlog maintenance, patient travel and congestion across the portfolio.

The estate varies in age, size and adaptability. Older premises are often more difficult to reconfigure for modern service requirements, making prioritised investment and service-led estate planning essential.

Delivery priorities are to strengthen community provision, improve access and prevention, and modernise acute sites around their core roles. Optimising community assets and working with partners will enable appropriate activity to move closer to home and release acute capacity.

5.2 Shifts to community and neighbourhood estate

As part of the community services review, working in collaboration with system partners, we will explore and implement opportunities to make more intensive use of community assets, including those secured through NHS Property Services asset transfer. This will support the appropriate relocation of services from acute settings into community-based environments across Lincolnshire.

The Plan will be updated as service models develop, funding is confirmed and schemes progress through design and approval. Immediate priorities are to advance feasibility studies, strengthen programme governance and progress priority schemes. Priorities and sequencing will be refined to support high-quality, integrated and sustainable care.

5.3 Optimisation of the acute sites

Each acute site will have a defined role within the wider system. Investment will address historic estate constraints, improve clinical adjacencies and navigation, and strengthen infrastructure for digital innovation, workforce productivity and long-term resilience.

Working with community teams and system partners will enable acute hospitals to be reconfigured around specialist, emergency, elective and inpatient care as services evolve.

This will improve patient flow, release space for priority services and make better use of existing capacity.

5.4 Post plan next steps

The next steps are to progress phased feasibility studies, prioritise capital investment and develop business cases through established governance. The objectives in Figure 17 will guide programme delivery, supported by system alignment and continued partner engagement.

Community provision and release of acute capacity

- Register an interest in awarded NHSE community and neighbourhood capital to ensure it maximises support for this shift and aligns with service transformation objectives.
- Work with local partners to explore how continued expansions of current CDC provision will be developed to allow for more activity to move off the acute sites. Further discussions will be progressed with our system partners and Lincolnshire Council to determine the most appropriate location to best serve the patient population with these neighbourhood care provisions.
- Develop a programme of feasibility studies to appraise options for the future use of identified assets, including repurposing or disposal where appropriate:
  - Aged acute buildings
  - Aged community buildings where a new build may be the most viable option
  - Underutilised office space e.g. home and flexible working in conjunction with hot desks.

To support the progression of these schemes, business cases will be developed where appropriate, with capital funding considered through a mix of business-as-usual capital, NHSE-awarded funding and Public-Private Partnerships (PPP).

Future actions are shown in the roadmap:

Figure 18. Implementation roadmap

Appendices

Appendix A – Technical Appendix

Appendix B – Site List Overview

Appendix C – Development Control Plans

Appendix D – Model Hospital Reports May 2026

Appendix E – Group Structure

Appendix F – Workshop Summary Notes

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Technical Appendix - Estate Strategy

August 2026

Contents

1. Where are we now?

1.1 Backlog maintenance breakdown

1.2 Estate efficiency breakdown

1.3 Benchmarking against peers

1.4 Space utilisation – methodology and key challenges detail

1.5 Current estate performance – Premises Assurance Model Trust breakdown

1.6 Energy – Technical detail and Trust breakdown split

2. How do we get there?

2.1 Funding and resourcing

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Schedule of **tables**

Table 1. LCHG backlog costs breakdown by site, (ERIC 2024/25)

Table 2. Capital investment and funding (source: ERIC 2024/25)

Table 3. Backlog Maintenance - peer comparison

Table 4. Comparison of annual occupation cost per m2 of gross internal area of floor area based on the 2024/25 ERIC dataset

Table 5. Comparison of use categories by percentage based on the 24-25 ERIC dataset

1. Where are we now?

1.1 Backlog maintenance breakdown

Table 1. LCHG backlog costs breakdown by site, (ERIC 2024/25)

Site	Site type	Tenure	Cost to eradicate backlog (£)				Total backlog (£)
			High risk	Significant risk	Moderate risk	Low risk	
Lincoln County Hospital	General acute hospital	Freehold	572,984	18,591,286	23,726,156	7,594,757	50,485,183
Pilgrim Hospital		Freehold	612,773	19,232,314	22,325,303	6,063,657	48,234,047
Grantham Hospital		Freehold	89,866	9,135,784	12,398,871	5,712,137	27,336,658
Community assets	Various	Mixed	3,951	78,525	252,369	213,378	548,223
Total			**1,279,574**	**47,037,909**	**58,702,699**	**19,583,929**	**126,604,111**

At the time of writing, Riversdale Health Clinic, which has a total backlog maintenance liability of £225,159, is planned to be disposed of from the Group's estate portfolio. Furthermore, this does not take into consideration the condition surveys that are currently going through the NHSPS asset transfer scheme.

The backlog is heavily weighted towards mechanical and electrical infrastructure that has reached the end of its recommended design life.

Key recurring condition issues across our major sites include:

- **Aged infrastructure:** Core mechanical and electrical systems across Lincoln, Pilgrim and Grantham are beyond design life, reducing reliability and increasing risk to service continuity.
- **Sub-ducts and steam systems:** Poor condition steam and condensate systems at Lincoln and Pilgrim are degrading adjacent services, with high energy and maintenance costs.
- **HV and electrical infrastructure:** Ageing switchgear, substations and transformers (some already beyond economic life) are unable to support future demand, posing risks to critical services.
- **Electrical resilience:** Backup generation is constrained and, in some cases, undersized, limiting resilience for essential services during power failure.
- **Fuel systems:** Ageing and degraded fuel storage presents risks to generator reliability, compliance and emergency response.
- **Ventilation compliance:** Outdated or non-compliant ventilation systems, particularly in specialist areas, pose risks to safety, compliance and service accreditation.
- **Building fabric and drainage:** Significant fabric deterioration and drainage failures are impacting estate condition, resilience and operational performance.
- **Statutory and fire safety**: Fire compartmentation, fire doors and wider compliance gaps increase risk of regulatory breach and safety incidents, including security and regulatory compliance requirements

1.2 Estate efficiency breakdown

Site footprint and utilisation

According to the latest ERIC data, the Group manages a vast and highly distributed footprint:

- LCHS reports a total of 39 site buildings, including four community hospitals with inpatient beds and 25 non-inpatient sites. 16 of these sites are leased from NHS Property Services.
- ULTH reports a total of 106 site buildings, which includes four general acute, four specialist and 10 mixed service hospitals, alongside 85 non-inpatient and support facilities. Notably, 74 of these sites are reported as being occupied without charges and six are leased from NHS Property Services.[1]
- This highly dispersed footprint reinforces the strategic necessity of our 'Left Shift' ambitions: to consolidate the estate, repurpose underutilised spaces and establish multi-agency hubs to improve overall utilisation.

[1] As of July 2026, Group services occupy approximately 50 sites and properties across Lincolnshire. ERIC reporting records individual buildings rather than sites and therefore reports a significantly higher number of estate assets represented in the Technical Appendix.

Capital investment and maintenance (2024/25)

Addressing inefficiencies requires targeted capital investment to improve existing infrastructure and tackle backlog maintenance. The 2024/25 ERIC data details the Group's recent capital deployments to improve and maintain the estate:

Table 2. Capital investment and funding (source: ERIC 2024/25)[2]

Investment category	Acute estate (ULTH)	Community estate (LCHS)	Group total
Capital investment for changing/improving existing buildings	£10,278,430	£351,122	**£10,629,552**
Capital investment for maintaining (lifecycle) existing buildings	£5,019,946	£0	**£5,019,946**
Capital investment for equipment	£441,027	£23,290	**£464,317**
Total public sector funding investment - Financial yr 2024/25	£67,093,588	£374,412	**£67,468,000**

Energy and sustainability efficiencies

As part of our commitment to the NHS Net Zero targets and reducing high utility costs, we are actively exploring energy efficiency schemes. Investment of £470,270 in energy efficient schemes was made during the 2024/25 period, with a Salix supported scheme of £2.49m during 2025/26. Expanding these initiatives across our wider portfolio will be essential to mitigating the high energy costs associated with older, less efficient buildings and legacy systems like steam and condensate distribution.

1.3 Benchmarking against peers

Backlog

The backlog maintenance benchmarking compares LCHG against a defined peer group of NHS organisations with similar acute and community estate profiles. These peers, East Sussex and Sussex Community (combined), County Durham and Darlington, Shrewsbury and Telford and Shropshire Community (combined) and Norfolk and Norwich with Norfolk Community (combined) reflect systems of comparable scale, service mix and estate complexity, providing a meaningful basis for assessing relative performance.

Table 3. Backlog Maintenance - peer comparison

Peer group	Backlog risk category (£/m2)				Totals (£/m2)	
	High	Sign	Mod	Low	Total (H&S)	Total (all backlog)
East Sussex and Sussex Community (Combined)	30.49	409.90	392.70	41.05	440.40	874.15
Lincolnshire Community and Hospitals Group	6.66	244.80	305.51	101.92	251.46	658.90
Shrewsbury and Telford and Shropshire Community (Combined)	15.32	244.76	97.80	18.67	260.10	376.55
Norfolk and Norwich University Hospitals and Norfolk Community (Combined)	13.21	31.08	99.19	45.00	44.29	188.50
County Durham and Darlington	9.21	33.70	65.49	11.18	42.90	119.58

This data and information highlights a high backlog maintenance burden across the estate, driven by ageing infrastructure and increasing risk to service continuity. It reinforces the need for the Estate Strategy to prioritise backlog reduction and ensure investment is targeted towards safety and long-term resilience.

Occupation cost

Benchmarking against peers on an occupation cost basis highlight that the Lincolnshire group sits broadly in the mid-range of the comparator set at a combined £747/m². This overall position is, however, driven by a significant divergence between the acute and community portfolios. The acute estate reports comparatively low occupation costs at £684/m², which is below or in line with similar acute-led systems, with costs distributed relatively evenly across building, Hard FM and Soft FM categories.

[2] It should be noted that the ERIC return reports £67.5m of public sector funding investment in 2024/25, whereas the Group's capital expenditure records identify total capital expenditure of £70.5m for the same period. The variance reflects differences in reporting methodologies and expenditure categories between the national ERIC dataset and the Trust's internal capital programme reporting.

The community estate represents a clear outlier within the peer set, with total occupation costs of £1,413/m². This variance is primarily attributable to building occupation costs rather than facilities management expenditure, indicating that the key driver is inherent to the property and occupation model rather than day-to-day operational efficiency. This suggests a need for targeted review of estate configuration, lease and charging structures and utilisation levels across the community portfolio.

Table 4. Comparison of annual occupation cost per m2 of gross internal area of floor area based on the 2024/25 ERIC dataset

Group	Cost category	Average site age	Cost per m2 of gross internal area					Total GIA (m2)
			Building occupation	Hard FM	Soft FM	Other	Grand total	
Norfolk and Norwich University Hospitals and Norfolk Community	Norfolk and Norwich University Hospitals NHS Foundation Trust	1985 to 1994	£655	£155	£266	£6	£1,082	142,853
	Norfolk Community Health and Care NHS Trust	1975 to 1984	£305	£121	£146	£5	£577	43,693
	Combined	1985 to 1994	£562	£146	£234	£5	£964	186,546
Shrewsbury and Telford and Shropshire Community (Combined)	Shrewsbury and Telford Hospital NHS Trust	1985 to 1994	£377	£148	£261	£8	£795	133,549
	Shropshire Community Health NHS Trust	1995 to 2004	£458	£88	£106	£16	£667	29,405
	Combined	1985 to 1994	£382	£145	£253	£9	£772	162,954
Lincolnshire Hospitals Group and Community Trusts	United Lincolnshire Teaching Hospitals NHS Trust	1975 to 1984	£254	£140	£276	£14	£684	171,036
	Lincolnshire Community Health Services NHS Trust	1955 to 1964	£1,197	£30	£158	£28	£1,413	21,111
	Combined	1985 to 1994	£336	£130	£265	£16	£747	192,147
East Sussex and Sussex Combined	East Sussex Healthcare NHS Trust	1985 to 1994	£317	£101	£220	£15	£653	145,326
	Sussex Community NHS Foundation Trust	1975 to 1984	£591	£40	£121	£20	£771	69,828
	Combined	1985 to 1994	£387	£86	£195	£16	£692	215,154
County Durham and Darlington	County Durham and Darlington NHS Foundation Trust	1995 to 2004	£357	£88	£145	£2	£592	18,936

Clinical and non-clinical use

We present a broadly typical profile relative to peers, with approximately 70% of space in clinical use and a mid-range allocation to general administration and other non-clinical functions. The proportion of support space is lower than some comparators, which may reflect a more streamlined or decentralised approach to operational functions.

Table 5. Comparison of use categories by percentage based on the 24-25 ERIC dataset

Group	Trust	Clinical	Admin / other	CSSD, medical records, HR, IT and staff accommodation	Restaurants and cafés, retail sales area
Shrewsbury and Telford and Shropshire Community	Shrewsbury and Telford Hospital NHS Trust	71%	22%	5%	3%
	Shropshire Community Health NHS Trust	67%	29%	3%	1%
	Combined	71%	22%	5%	3%
Lincolnshire Community and Hospitals Group	United Lincolnshire Teaching Hospitals NHS Trust	70%	26%	2%	2%
	Lincolnshire Community Health Services NHS Trust	72%	28%	0%	0%
	Combined	70%	26%	2%	1%
Norfolk and Norwich University Hospitals and Norfolk	Norfolk and Norwich University Hospitals NHS Foundation Trust	67%	25%	8%	1%
	Norfolk Community Health and Care NHS Trust	70%	29%	1%	0%
	Combined	67%	26%	6%	1%
County Durham and Darlington	County Durham and Darlington NHS Foundation Trust	65%	30%	2%	2%
Sussex	East Sussex Healthcare NHS Trust	53%	27%	20%	1%
	Sussex Community NHS Foundation Trust	60%	37%	2%	0%
	Combined	55%	29%	15%	1%

Overall, this indicates that we are not inherently high cost at a system level, with total estate costs broadly comparable to peers; however, this masks variation within the portfolio, particularly higher costs in the community estate.

NOTE. *The figures presented in this table are based on the total estate footprint, including occupied, vacant and non-operational space. By contrast, the Model Health System metrics referenced in the main Estate Strategy are calculated using occupied floor area (space currently in operational use) and national benchmarking methodologies. As a result, the figures are not directly comparable and differences should be expected.*

1.4 Space utilisation – methodology and key challenges detail

A detailed assessment of space utilisation was undertaken as part of the Six Facet Survey completed across the acute estate in 2023, supplemented by ongoing operational intelligence across the community estate.

The Six Facet Survey assessed how clinical and non-clinical spaces are currently used and categorised areas into four utilisation classifications:

- Empty (E) – space not in active use
- Under-Used (U) – space used below expected capacity or frequency
- Fully Used (F) – space used broadly as intended
- Overcrowded (O) – space operating beyond its intended capacity or suitability.

These findings were triangulated with operational feedback from site teams, service managers and estates colleagues, alongside local utilisation reviews of community and leased assets. This approach provides a consistent evidence base to identify patterns of congestion, underutilisation and inefficiency across the Group's estate, while recognising variation in service models, building age and ownership arrangements.

Key challenges

The space utilisation assessment identifies the following key challenges across the Group's estate:

- **Acute site congestion and overcrowding**
  Significant congestion exists within parts of the acute estate, particularly in high-intensity clinical areas. In many cases, space provision is constrained by historic layouts that are no longer suitable for modern clinical activity, contributing to inefficiencies in patient flow and staff working environments.
- **Legacy estate design constraints**
  A proportion of the acute estate was designed for historic models of care and does not readily support current clinical workflows, infection prevention requirements or expanded multidisciplinary team working. This limits flexibility and the ability to adapt space efficiently.
- **Underutilised space elsewhere in the portfolio**
  In contrast to acute congestion, there are pockets of empty or under-used space across the wider estate, reducing overall utilisation efficiency and value for money.
- **Fragmented community estate footprint**
  The community estate is distributed across a large number of sites, many of which are leased. This fragmentation results in duplication of accommodation, variable utilisation levels and reduced operational flexibility.
- **Limited flexibility of single-use spaces**
  A high proportion of space across the estate is configured for single or narrowly defined uses, constraining opportunities for shared, multi-agency or adaptable use aligned to emerging models of care.
- **Inconsistent utilisation data and monitoring arrangements**
  Variability in booking systems, data quality and utilisation monitoring limits the ability to consistently measure, compare and actively manage space use across the Group.
- **Operational constraints on releasing or repurposing space**
  Opportunities to repurpose or release space are often dependent on service relocation, decant capacity and capital investment, which can delay the realisation of utilisation benefits.
- **Misalignment between estate configuration and future service models**
  The current estate configuration does not always align with emerging neighbourhood-based models of care or the Group's 'Left Shift' ambition, reinforcing the need for consolidation, repurposing and more flexible space planning.

1.5 Current estate performance – Premises Assurance Model Trust breakdown

Community estate (LCHS)

The LCHS PAM submission reveals a more mixed picture. While the Trust demonstrates sound and stable governance, good patient experience and pockets of strong operational practice (such as cleanliness), there are significant areas of concern. The assessment highlights a critical need for systematic improvement across safety and technical compliance.

A review of the raw Self-Assessment Questionnaire submission data corroborates this, flagging that 'moderate improvement' (4) is required across several core Hard FM domains, including water safety, electrical systems, ventilation, lifts and asbestos management. Critical concerns raised in the baseline review include a widespread lack of costed action plans for these non-compliant areas, a siloed FM structure, low digital maturity and concerning gaps in statutory safety and compliance appointments.

Acute estate (ULTH)

The ULTH assessment presents a broadly stable facilities and maintenance (F&M) environment. The assurance picture is positive overall, with most domains assessed as 'Good' (2) and no 'Inadequate' (5) ratings recorded. The Trust's strongest performance areas lie within governance, patient experience, soft FM safety and efficiency.

However, the assessment identifies a requirement for improvement across certain 'Hard FM' domains. There are recurring areas requiring minimal (3) to moderate (4) improvement, particularly concerning the maintenance of specific systems and effectiveness in sustainability and planning. Furthermore, the review highlighted specific gaps regarding statutory compliance with recent terrorism legislation, alongside a concerning trend of declaring £0 for costed action plans across non-compliant areas.

1.6 Energy – Technical detail and Trust breakdown split

ULTH demonstrates high overall energy consumption and cost relative to its peers, with total energy spend of £8.48m and total consumption of 85.42 million kWh in 2024/25. This equates to £51.76 per m² and 521.10 kWh per m², compared to peer averages of around £45 per m² and 419 kWh per m².

At a service level, ULTH records energy use of £7.54 per patient and 75.91 kWh per patient, compared to peer benchmarks of approximately £7.58 per patient and 74.56 kWh per patient.

LCHS demonstrates low energy consumption and cost relative to its peers, with total energy spend of £201k and total consumption of 950,310 kWh in 2024/25. This equates to £10.13 per m² and 47.84 kWh per m², compared to peer averages of around £45 per m² and 419 kWh per m².

At a service level, LCHS records energy use of £1.96 per patient and 9.26 kWh per patient, substantially below peer benchmarks (approximately £7.58 per patient and 74.56 kWh per patient).

2. How do we get there?

2.1 Funding and resourcing

NHS Long Term Plan

The Secretary of State issued revised financial directions to NHS England on 25 March 2026, setting revenue and capital resource limits for the 2025/26 financial year. The NHS is expected to operate within these constraints while supporting service recovery, transformation and efficiency through national planning guidance.

Key national financial expectations for 2025/26 include:

- Delivering overall revenue and capital financial balance across NHS systems.
- Achieving efficiency savings and improving productivity within available resources.
- Supporting service recovery, including elective performance, in line with national operational priorities.

It is essential that the **strategic objectives**, particularly around estates, digital transformation and service delivery, align with the ambitions of the NHS Long Term Plan and national financial priorities, ensuring investment decisions remain affordable, outcomes-focused and consistent with system-level planning.

Capital Departmental Expenditure Limit (CDEL)

NHS Trusts have limited access to capital; this is allocated each year by NHSE to all local health systems and in turn to each Trust. This capital allocation forms part of the national capital departmental health expenditure limit. Capital is used to pay for maintenance of existing hospital estate, for investment in new facilities and demand often considerably outweighs availability.

As well as setting limits on direct capital expenditure, the capital department expenditure limit takes account of a Trust's other financial commitments and control of its assets under relevant accounting standards.

In 2022 a new international accounting standard (IFRS16) was introduced, in which an organisation's operating leases and other, similar occupancy arrangements count towards the capital department expenditure limit allocation. As these items had not been previously included in the expenditure limit, the approaches that Trusts can use when entering leases or other arrangements, as well as commitments with accommodation providers are further limited. Any major future capital expenditure programmes or development control plans will have to take the Trust or system- wide capital department expenditure limit into consideration.

Public Sector Decarbonisation Scheme (PSDS)

To reach national net zero carbon targets, it is recognised that organisations will require external funding. The Department for Business Energy and Industrial Energy Strategy have released grant funding through the Public Sector Decarbonisation Scheme and applications for this money must be supported with a robust business case and technical appraisals. To ensure organisations are prepared for future rounds of funding, detailed feasibility studies should be completed in readiness for funding becoming available.

Areas for funding application may include:

- Heat recovery and controls from existing combined heat and power
- Upgrading electrical infrastructure
- Renewable energy, including solar
- Insulation, glazing and ventilation
- LED lighting and controls
- Efficient information and communication technology
- Building modelling system integration
- Motor controls
- Metering and battery storage.

The Carbon and Energy Fund (CEF)

The Carbon and Energy Fund is a unique financing mechanism and collaborative UK platform that supports NHS Trusts and public sector organisations in achieving energy efficiency and carbon reduction targets.

The fund brings together expertise from various stakeholders, including NHS Trusts, industry partners and funders, to deliver energy infrastructure projects and implement sustainable solutions. By leveraging long-term, off-balance-sheet financing, the Carbon and Energy Fund enables Trusts to undertake energy efficiency upgrades, renewable energy installations and carbon reduction initiatives with minimal upfront costs.

Services provided by the CEF include:

- Providing skilled advisors for the life of the project.
- Use of CEF's proven Energy Services Performance contract, which transfers risk, guarantees savings and has been shown to be off balance sheet under IFRS.
- Funding when bidder cannot provide better funding or grants to support the project.
- Managing the CEF framework leading to fewer procurement issues and contractor problems.
- Overseeing the project installation phase and certifying practical completion to support member organisation's team.
- Use of CEF framework procurement model for member organisations.
- Recovering all CEF costs from contractor, so the organisation doesn't pay advisor costs and only pays after the project is installed, proven and handed over to operations.
- Auditing the project monthly, quarterly and annually.
- Providing legal support for the process of making the standard project agreement.

The innovative funding model helps Trusts to reduce their carbon footprint and energy costs, but also improves patient care by creating more comfortable and sustainable healthcare environments. The carbon and energy fund plays a vital role in supporting the NHS' sustainability agenda, driving energy innovation and delivering tangible benefits for healthcare organisations and the environment.

The route to delivering a scheme through the carbon and energy fund is a five-stage process, beginning with seeking membership, defining a scheme, the entire procurement process, contract, installation and managing the monitoring period of the contract.

Prepared on behalf of and in conjunction with
Lincolnshire Community and Hospitals NHS Group by

Archus
The healthcare infrastructure specialist

S/n	Site	Tenure	Type	GIA (m2)	GIA notes	Total Valuation (NBV)	Backlog (NHSPS) £
1	Lincoln County Hospital	Freehold	Acute	78275		£110,343,345.99	£50,485,183
2	Grantham & District Hospital	Freehold	Large Community Hospital	28314		£28,936,675.01	£27,336,658
3	Pilgrim Hospital Boston	Freehold	Acute	2974		£72,194,928.73	£48,234,047
4	County Hospital Louth	Leased	Community Hospital	5855		£9,885,452.00	£5,655,858
5	John Coupland Hospital	Leased	Community Hospital	3125		£14,097,200.00	£3,074,392
6	Johnson Community Hospital	Leased	Community Hospital	3493		£24,713,048.00	n/a
7	Skegness Hospital	Leased	Community Hospital	2388		£3,437,900.00	£2,584,044
8	Skegness CDC	Freehold	Diagnostics	934		£7,876,626.49	
9	Lincoln CDC	Freehold	Diagnostics	1723		£13,369,203.18	
10	Grantham CDC	Freehold	Diagnostics	947		£1,975,379.58	
11	Boston CDC	Freehold	Diagnostics	n/a	Under-construction	Under-construction	
12	Bourne Health Clinic	Freehold	Community Care	998.83	Level 00 + 001	£1,465,676.00	
13	Grace Swan Health Clinic	Freehold	Community Care	479		£688,827.00	
14	Ravendale Health Clinic	Freehold	Community Care	272.55	Level 00	£358,487.00	
15	Riversdale Health Clinic	Freehold	Community Care	673.91	Level 00 +01+02+03	n/a	
16	Ironstone Centre	Leased	Sexual Health	2420.45	Level 01	n/a	
17	Gainsborough Children's Centre	Leased	CYP Service		No information available	n/a	
18	Pottergate Health Centre	Leased	Sexual Health	918.76	Level 00	£316,291.00	£242,407

19	Skegness Health Clinic	Leased	Community Care	548.45	Level 01	n/a	
20	Quayside Medical	Leased	Sexual Health		No information available	n/a	
21	Newland Medical Centre	Leased	Community Care		No information available	n/a	
22	Unit 20 – Enterprise Park	Leased	Warehouse	92.74	Level 00	n/a	
23	Unit 23 – Enterprise Park	Leased	Warehouse	139.49	Level 00	n/a	
24	Marisco Medical Practice	Leased	Community Care	1731.49	Level 00 NHPS Top left would need to	n/a	
25	Alford War Memorial	Leased	Community Care		No information available	n/a	
26	63 Monks Road	Leased	Community Care (walk in centre)	377.81	Level 0B + 00 + 01 There is a basement x 2. Earl to draw on basement	n/a	
27	179 High Street Lincoln	Leased	Accommodation		No information available	n/a	
28	Beech House	Leased	Offices	2420	No information available	n/a	
29	Lindon House	Leased	Sexual Health	491.36	Level 00 + 01	n/a	
30	Fen House	Leased	Community Care	642	No information available	n/a	
31	North Hykeham Health Clinic	Leased	Community Care	893.04	Level 00	n/a	
32	Birchwood Health Centre	Leased	Community Care	993.96	Level 00	n/a	
33	Caistor Health Centre	Leased	Community Care	594.37	Level 00	n/a	
34	Horncastle War Memorial Centre	Leased	Community Care		No information available	n/a	
35	Grantham Health Clinic	Leased	Community Care	447.55	Level 00 No information for first floor	£2,112,052.00	£318,957
36	Unit 14, The Point, NG34	Leased	Community Care	125.04	Level 00	n/a	
37	Unit 15, The Point, NG34	Leased	Community Care	127.28	Level 00	£119,906.00	£21,229

38	Unit 7, The Point, NG34	Leased	Community Care	148.91	Level 00	n/a	
39	Long Sutton Medical Centre	Leased	Community Care	~200	Level 00 + 01	n/a	
40	Venture House	Leased	Community Care teams	1144.10	Level 01	n/a	
41	The Sidings Medical Centre	Leased	Community Care		No information available	n/a	
42	Boston Health Clinic	Leased	Community Care	841.40	Level 00	£629,890.00	£527,662
43	Butterfly Hospice	Leased	Palliative Care		No information available	n/a	
44	The Deepings Health Centre	Leased	Community Care		No information available	n/a	
45.1	Stamford & Rutland Hospital – Hurst Ward	Leased	Inpatient care		3 rooms main bit	n/a	
45.2	Stamford and Rutland Hospital – clinic A	Leased	Community Care		Only occpa a bit Clinic 7 and 8 and a staff room	n/a	
46	Gainsborough Health Clinic	Leased	Community Care	1092.70	Level 00	n/a	
47	Unit 1 Greetwell Road	Leased	Warehouse		No information available	n/a	
48	Unit 1, Boole Technology Centre, Lincoln Science and Innovation Park	Leased	Offices	~200	Level 01 - Boole Technology Centre Tbc	n/a	
49	Pinnacle House	Leased	Offices		No information available	n/a	
50	Warehouse 6 LN6	Leased	Warehouse		No information available	n/a	
	NHPS Asset Transfer properties						
PS51	Richmond Medical Practice	Leased	Community Care	628.00	No information available	£656,661.00	£7,819
PS52	Saxilby Health Centre	Leased	Community Care	1088.00	No information available	n/a	£82,368
PS53	Skegness Day Centre	Leased	Community Care	313.00	No information available	£3,437,900.00	£49,242

PS54	Crowland Health Clinic	Leased	Community Care	404.00	No information available	£560,131.00	£150,000

Gilling Dod

Lincolnshire Community Hospitals Group

Development Control Plan

P05 30.09.2026

Document Control

Project Name: Lincolnshire Development Control Plan
Project Code: 9157-001
Client: Lincolnshire Community Hospitals Group

Revision	Date	Description	Author	Approved
P01	21.04.2026	First Issue WIP	CLS	RG
P02	23.06.2026	Updated following workshops – Draft Issue	LC	CLS
P03	28.07.2026	Updated following conditions mapping meetings	LC	CLS
P04	04.08.2026	Minor updates to slides 6.1, 6.2 & 6.5 following feedback received 03/08.	LC	CLS
P05	30.09.2026	Updates to potential development slides following Trust meeting 01/09.	CLS	RG

Contents

Introduction 1

1.1 Project Introduction and Brief
1.2 Wider Estate
1.3 Key Focussed Sites

Existing Site Plans 2

2.1 Lincoln County Hospital Existing Site Plan
2.2 Pilgrim Hospital Existing Site Plan
2.3 Grantham and District Hospital Existing Site Plan
2.4 Louth County Hospital Existing Site Plan
2.5 Skegness Hospital Existing Site Plan
2.6 John Coupland Hospital Existing Site Plan

Existing Site Analysis 3

3.1 Lincoln County Hospital Site Analysis
3.2 Pilgrim Hospital Site Analysis
3.3 Grantham and District Hospital Site Analysis
3.4 Louth County Hospital Site Analysis
3.5 Skegness Hospital Site Analysis
3.6 John Coupland Hospital Site Analysis

Existing Conditions Plans 4

4.1 Lincoln County Hospital Existing Conditions Plan
4.2 Pilgrim Hospital Existing Conditions Plan
4.3 Grantham and District Hospital Existing Conditions Plan
4.4 Louth County Hospital Existing Conditions Plan
4.5 Skegness Hospital Existing Conditions Plan
4.6 John Coupland Hospital Existing Conditions Plan

Planned Projects & Opportunities 5

5.1 Lincoln County Hospital Planned Projects & Opportunities
5.2 Pilgrim Hospital Planned Projects & Opportunities
5.3 Grantham and District Hospital Planned Projects & Opportunities
5.4 Louth County Hospital Planned Projects & Opportunities
5.5 Skegness Hospital Planned Projects & Opportunities
5.6 John Coupland Hospital Planned Projects & Opportunities

5-10 Year Potential Development Sites 6

6.1 Lincoln County Hospital Potential Development Sites
6.2 Pilgrim Hospital Potential Development Sites
6.3 Grantham and District Hospital Potential Development Sites
6.4 Louth County Hospital Potential Development Sites
6.5 Skegness Hospital Potential Development Sites
6.6 John Coupland Hospital Potential Development Sites

1

Introduction



1.1 Project Introduction & Brief

Following an appointment by Lincolnshire Community Hospitals Group (LCHG), we are working with Archus to assist in the development of the Lincolnshire Estates Strategy 2026-2036, specifically in the production of the Development Control Plans.

Key Focussed Sites

Whilst the Estates Strategy will provide an overarching review of the county and the wider estate, the DCP's intend to focus on 6No key sites:

- Lincoln County Hospital
- Pilgrim Hospital Boston
- Grantham & District Hospital
- John Coupland Hospital
- County Hospital Louth
- Skegness Hospital

The Development Control Plans identify key areas across the sites with potential for future development, alongside condition mapping to support a clear understanding of estate requirements. The DCPs will provide a valuable reference point for future planned projects, helping to improve adjacencies, enhance service delivery and support informed decision-making across the portfolio.

Existing Site Analysis

All Acute site plans are based on the latest Trust records as circulated June 2026. Section 3 provide desk-top survey based & site visit evidence to analyse the existing DCP sites. Section 4 reflects the Trust's Acute Hospitals 6 Facet Survey dated March 2026.

Proposed Development Options

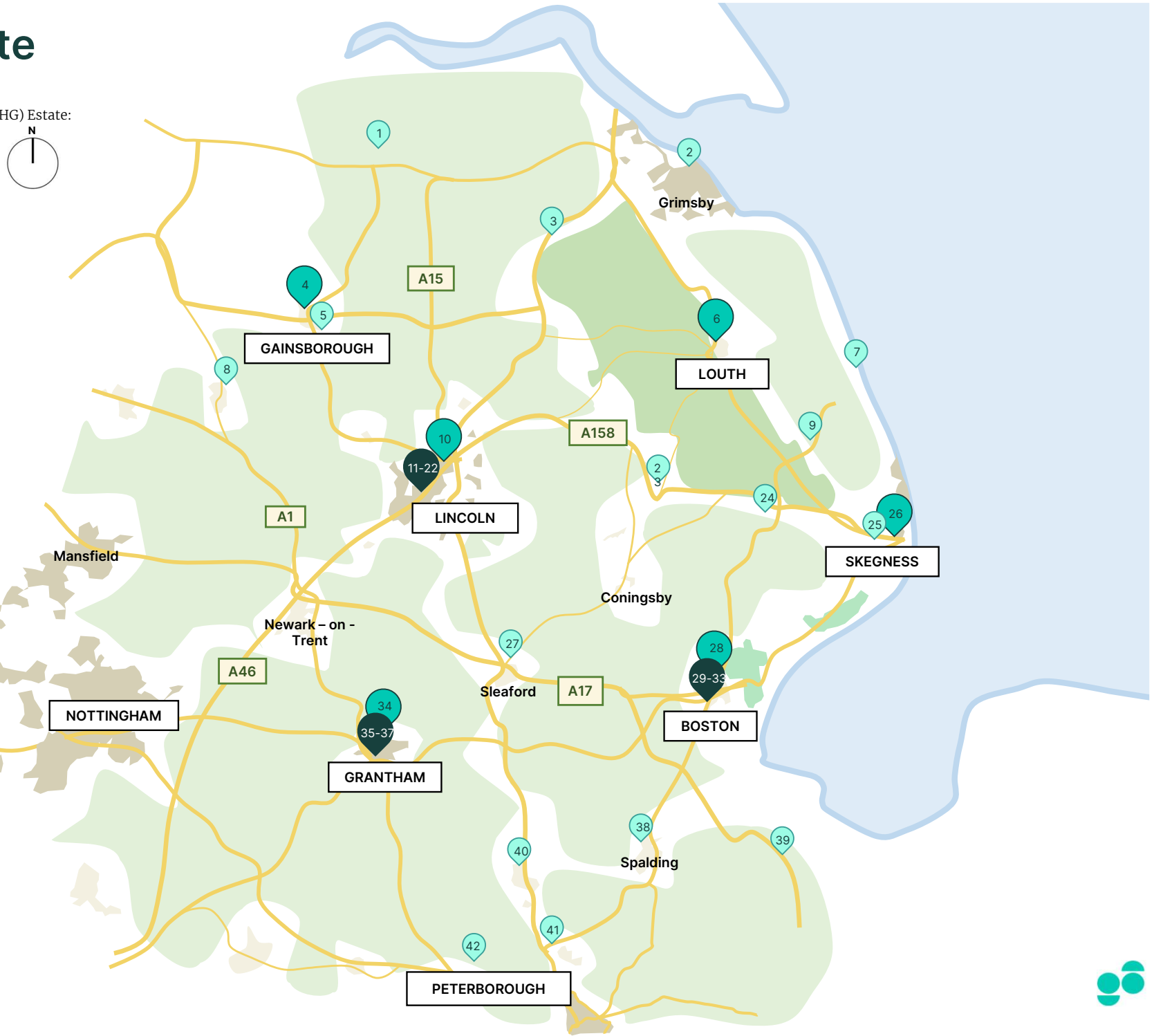
Following on from the Group Workshops held in May 2026 and subsequent Estates meetings, **increased capacity need (within next 5 years) and proposed left shift moves have been suggested. These, together with the plotting of proposed capital projects and backlog maintenance investment have allowed us to highlight potential areas of future development opportunity.**

This report reflects the initial review of the DCP exercise, providing a series of development options that can be reviewed and analysed against the wider estate's strategy. To add to this will be the development opportunities of the community sites; subject to further asset information and engagement taking place. Once Group feedback is received, there is the opportunity to look more closely at specific development zones and provide more detailed strategic considerations, providing a clear direction on priorities, scope and costs.

1.2 Wider Estate

Lincolnshire Community Hospitals Group (LCHG) Estate:

- Denotes built up area
- Denotes town / city centre
- Focus Sites
- Other NHS Sites



1. Ironstone Centre
2. Stirling Medical Centre
3. Caistor Health Centre
4. John Coupland Hospital
5. Gainsborough Children's Centre
6. County Hospital Louth
7. The Marisco Medical Practice
8. Riverside Health Centre
9. 4 Chauntry Road
10. Lincoln County Hospital
11. Riverside Enterprise Park
12. Ravendale Health Centre
13. Lincoln Community Diagnostics Centre
14. Newland Health Centre
15. Queensgate House
16. 59 & 63 Monks Road
17. 179 High Street
18. Beech House
19. Lindon House
20. Birchwood Medical Practice
21. Lincolnshire Community Health Services
22. Fen House
23. War Memorial Hospital
24. Grace Swan Health Clinic
25. Skegness Community Diagnostic Centre
26. Skegness and District General Hospital
27. Lions Way
28. Pilgrim Hospital
29. The Butterfly Hospice Trust
30. Boston Enterprise Centre
31. Boston Health Clinic
32. The Sidings Medical Practice
33. Boston College
34. Grantham and District Hospital
35. Community Diagnostic Centre Grantham
36. Grantham Health Clinic
37. Grantham Community Base
38. Johnson Community Hospital
39. Long Sutton Medical Centre
40. Bourne Health Clinic
41. The Deepings Practice
42. Stamford and Rutland Hospital

1.3 Key Focussed Sites

Lincolnshire Community Hospitals Group (LCHG) Estate:

- Denotes built up area
- Denotes town / city centre
- Focus Sites
- Other NHS Sites

1 **John Coupland Hospital**
Gainsborough, General Hospital

2 **County Hospital Louth**
Louth, General Hospital

3 **Lincoln County Hospital**
Lincoln, General Hospital

4 **Skegness Hospital**
Skegness, General Hospital

5 **Pilgrim Hospital Boston**
Boston, General Hospital

6 **Grantham & District Hospital**
Grantham, General Hospital



1.3 Key Focussed Sites

Key DCP Sites:

- Denotes built up area
- Denotes town / city centre
- Focus Sites
- Other NHS Sites

1 **John Coupland Hospital**
Gainsborough, General Hospital

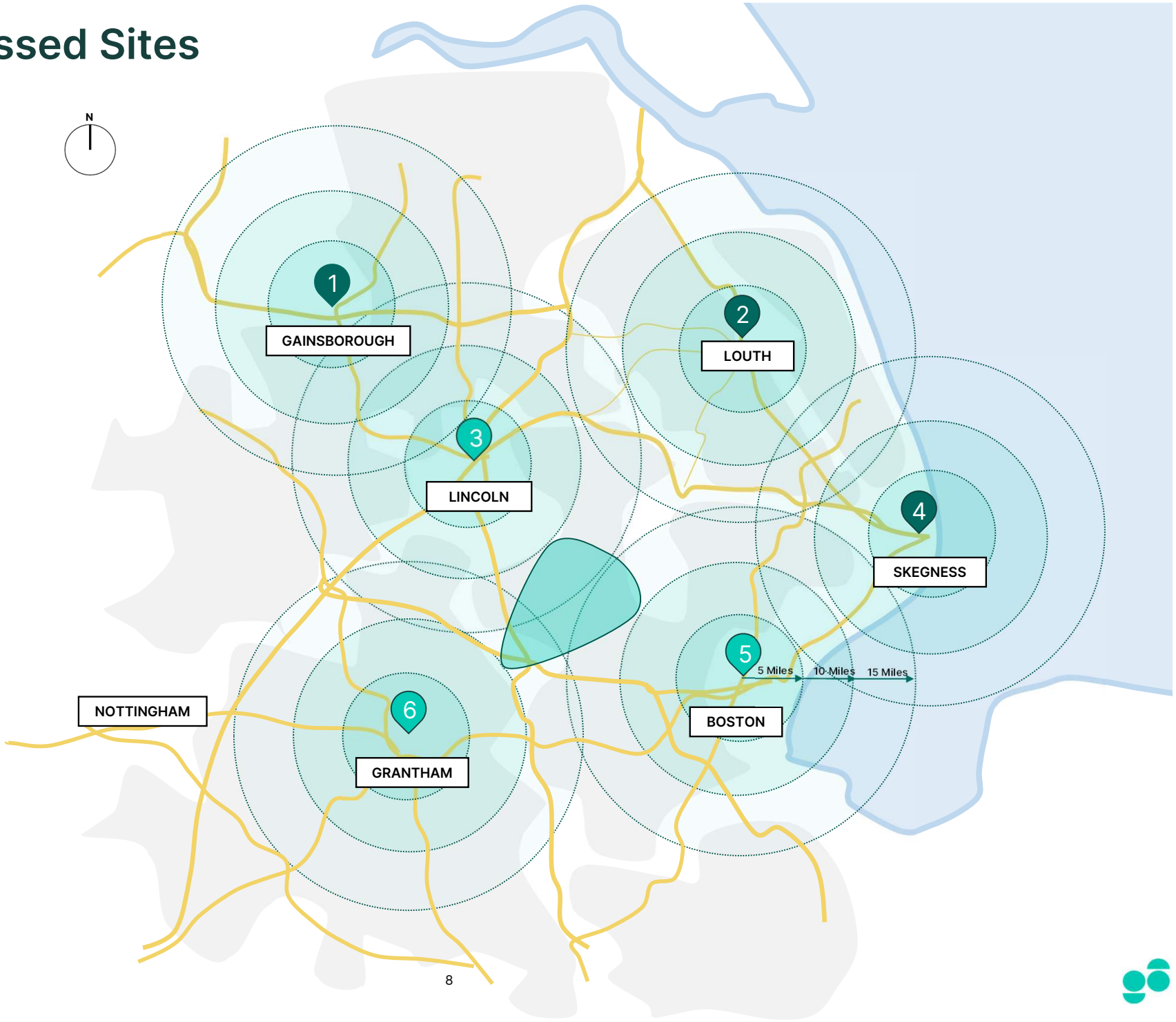
2 **County Hospital Louth**
Louth, General Hospital

3 **Lincoln County Hospital**
Lincoln, General Hospital

4 **Skegness Hospital**
Skegness, General Hospital

5 **Pilgrim Hospital Boston**
Boston, General Hospital

6 **Grantham & District Hospital**
Grantham, General Hospital



2

Existing Site Plans

2.1 Lincoln County Hospital Existing Site Plan



Key

AA Facilities Block
AB Hospidea
AC Finance Department
AD Offices
AE Occupational Therapy
AF Creche and Rheumatology Block
AG Rheumatology
AH Switchroom
AJ Link Corridor
AK Physiotherapy
AL 3 Ward Block
AM Pharmacy Medical Gas Store
AN Out Patients Department Block
AO Pathology Block
AP A&E X-Ray Block
AQ Link Corridor
AR Plant / Equipment
AS Ward / Theatre Block
AT Main Entrance, Trust Board Offices & ICU Block
AU Ward Block
AV Ward Block
AW Ward Block
AX Ward Block
AY Radiotherapy Block
AZ Endoscopy Unit

OA Staff and Social Block
OB Robey House
OC Maternity Wing
OD MacMillan and Breast Care Nurses
OE Gas Meter Room
OI Maternity Wing Link Corridor
OJ CPU and Social Workers
OK Electrical Switchroom & Med Gas Equipment
OL Offices
OM Estates Offices and Workshops
ON Estates Wood Store
OO Gardeners Store
OP Generator House / Sub-Station
OQ Estates Changing Facilities / Accommodation
OS Breast Screening
OT Offices
OU Old Payroll Block
OV Post Graduate Education Centre and Offices
OW Estates Stores
OY Estates Joiners Workshop
OZ Boiler House Block

BA Generator House 8
BB Energy Centre Block
BC Renal Unit
BD Car Parking Office
BG Urgent Treatment Centre
BJ Temporary Diagnostic Units
BL Resus
BM Data Centre 3
BN Data Centre 4
BO IT Office/Workshop
BR Endoscopy

ZA Hazel House (Progress Living)
ZB Accommodation (Progress Living)
ZC Accommodation (Progress Living)
ZD Accommodation (Progress Living)
ZE Accommodation (Progress Living)
ZF Accommodation (Progress Living)
ZH Accommodation (Progress Living)
ZI Accommodation (Progress Living)
ZJ Accommodation (Progress Living)
ZK Accommodation (Progress Living)
ZL Accommodation (Progress Living)

2.2 Pilgrim Hospital Existing Site Plan

Key

OA Main Tower Block
OB Maternity Block
OC Modular Building
OD Old MDU Block
OE Childrens Clinic, Old Stroke Unit
OF Bostonian Block
OG Ward Block
OH Psychiatry Block
OI Kitchen Stores and Linen Block
OJ Theatre Block
OK Chapel
OL Pathlincs Block
OM Dirty Linen and Garages Block
OO Education Centre Block
OP Ambulance Station
OQ Gardeners Area Block
OR Boiler House Block
OS Estates and Facilities Block
OT Physio and OT Block
OU ENT and X-Ray Block
OV Outpatients Department Block
OW AEC, AMU and Theatre Block
OY Estates
OZ East Skirbeck House Block
AA Day Nursery
AD Pump House Block
AE Meter House Block
AK Emergency Department
AJ Data Centre
ZA Bolingbroke House (Progress Housing)
ZB Tattershall House (Progress Housing)
ZC Grimsthorpe House (Progress Housing)
ZD Progress Housing
ZE Progress Housing

Legend

Site Boundary

Road & Parking

Buildings

Green Space

Trees



2.3 Grantham and District Hospital Existing Site Plan

Key

OA Ophthalmology, Training Rooms & Staff Offices
OB Manthorpe Centre (LPFT)
OC Ward and St Barnabas Block
OD Theatre Block
OE A&E, X-Ray and Endoscopy
OF Outpatients Departments
OG Outpatients Departments
OH Outpatients Departments
OI Ward Block
OJ MRI Department
OK Ward, Kitchen and Restaurant Block
OL Tower Block
OM Mortuary and Linen Rooms
ON Old Facilities Offices
OO Old Boiler House Block
OP Facilities Department & Sexual Health Block
OQ Plant Rooms / Water Meters
OR Progress Housing
OS Manthorpe House (Progress Housing)

Legend

Site Boundary

Road & Parking

Buildings

Green Space

Trees



2.4 Louth County Hospital Existing Site Plan

Key

Block 1 Voluntary Car Service
Block 6 Facilities/Hospital Main Reception & Primary Care Clinics
Block 7 Midwives
Block 8 Workhouse Diner
Block 14 Occupational Therapy/Physiotherapy
Block 15 Preston House
Block 16 Estates
Block 17 Laboratory (Blood Test)
Block 19 Pharmacy
Block 21 Outpatient Department
Block 24 MRI Scanner
Block 27 Main Block
LG: A-Ray/Theatrs/Ultrasound
FF: Fotherby Ward/Pre-Assessment /Musculoskeletal/Ecotech/Dermatology
SF: Thoresby Suite/Diabetes/Linen Room
Block 42 Link Corridor
Block 43 Woldside/Urgent Care Centre
Block 44 Endoscopy Unit/Urology Unit
Block 45 Archer Ward/Archer Assessment (Offices)
Block 46 Estates Stores
Block 47 Estates Stores
Block 48 Old Morgue (Vacant)
Block 49 Old Laundry/Store
Block 50 Boiler Room & Stores

Legend

Site Boundary

Road & Parking

Buildings

Green Space

Trees



2.5 Skegness Hospital Existing Site Plan

Key

Block 1 Community Day Centre
Block 2 Outpatients (Incl. Occupational Therapy/Physiotherapy)
Block 3 Plant Room & Generator
Block 4 Link Corridor
Block 5 External Store & Bike Shed
Block 6 Scarborough Ward
Block 7 Ward
Block 8 Outpatients
Block 9 Old Store & Couryard
Block 10 Property Services & Facilities Management
Block 11 Urgent Treatment Centre
Block 12 Old Morgue & Stores
Block 13 Oaks Block

Legend

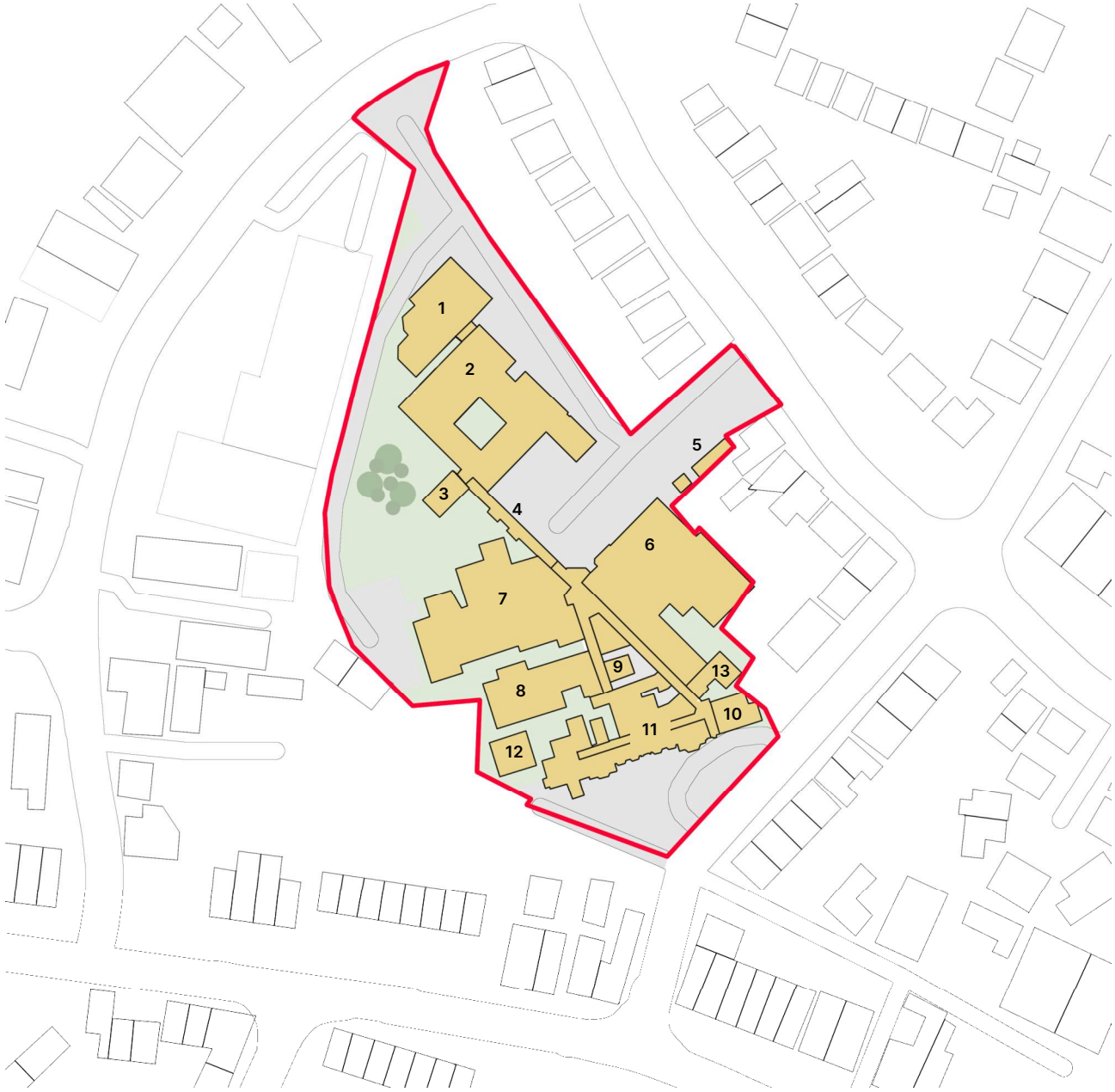
Site Boundary

Road & Parking

Buildings

Green Space

Trees



2.6 John Coupland Hospital Existing Site Plan

Key

Block 1	Theatre Ward
Block 2	Theatre
Block 3	Main Entrance & Waiting
Block 4	Bookable Rooms
Block 5	Stores
Block 6	Vacant Outbuilding
Block 7	Urgent Treatment Centre
Block 8	X-Ray & Ultrasound
Block 9	Outpatient/Bookable Rooms
Block 10	Dining Room
Block 11	Kitchen
Block 12	Plant & Generator
Block 13	Old Scotter Wards (Vacant)
Block 14	Estates Workshop
Block 15	Existing Physiotherapy (Vacant)
Block 16	Link Corridor
Block 17	New Scotter Ward
Block 18	Vacant Block

Legend

- Site Boundary
- Road & Parking
- Buildings
- Green Space
- Trees



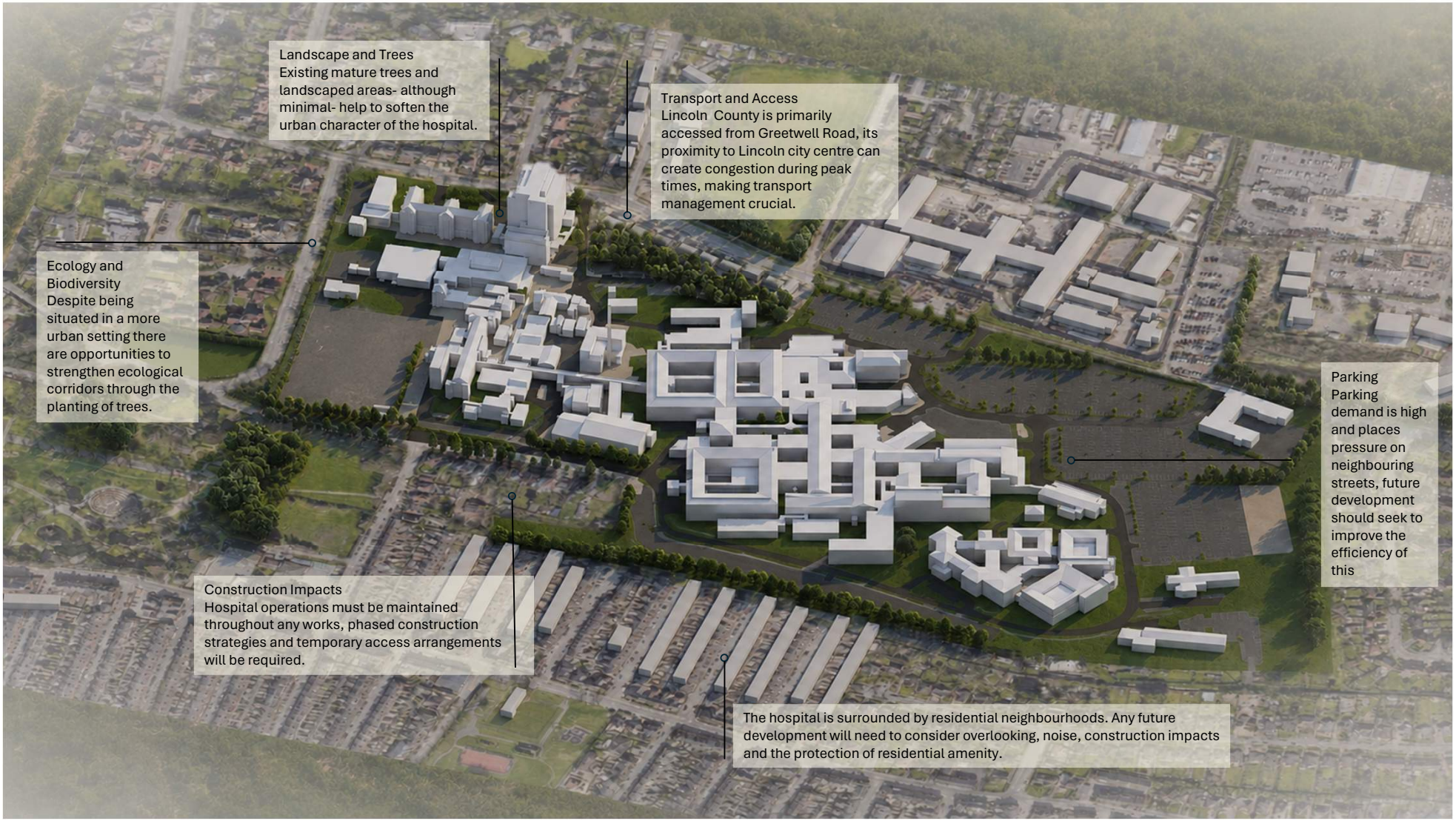
3

Existing Site Analysis

3.1 Lincoln County Hospital Site Analysis

Opportunities, Constraints and Challenges

The constraints, opportunities and challenges at Lincoln County include access and transport, neighbouring residential areas, heritage assets parking provisions and maintaining hospital operations during construction.

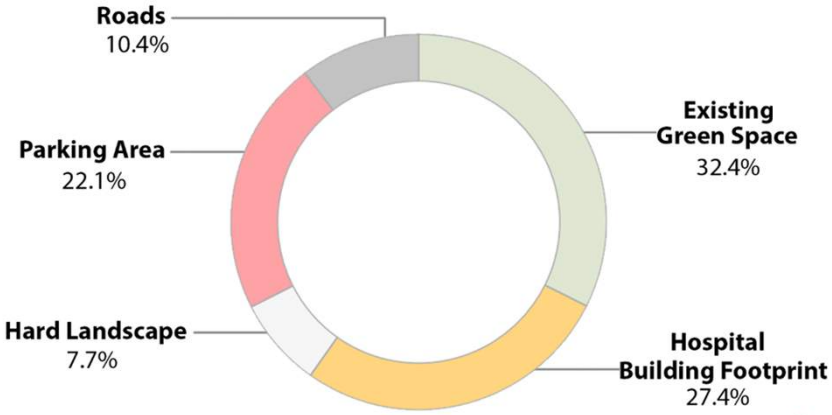


3.1 Lincoln County Hospital Site Analysis

Existing Site Analysis of Land Use:



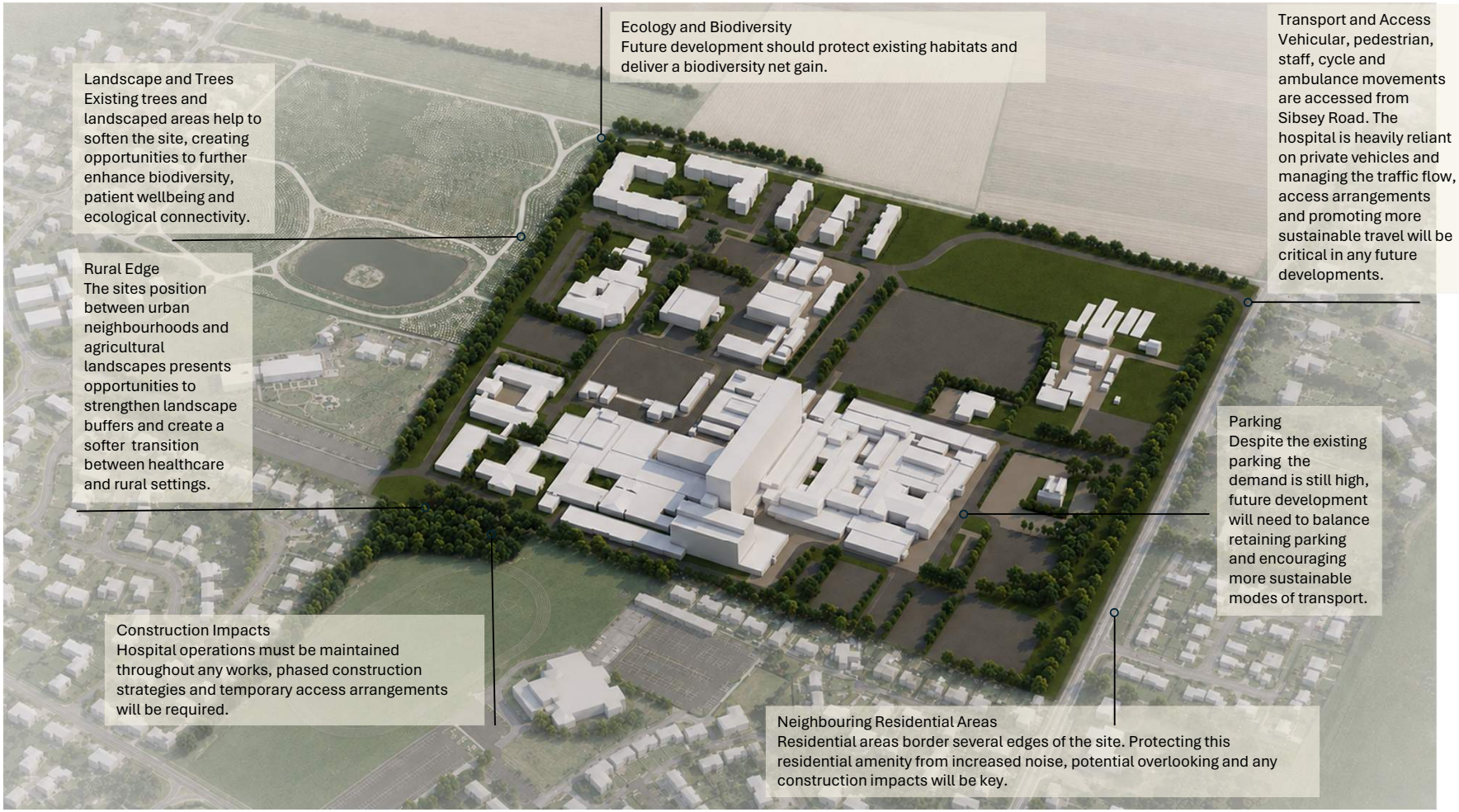




3.2 Pilgrim Hospital Boston Site Analysis

Opportunities, Constraints and Challenges

Pilgrim hospital has a number of constraints, opportunities and challenges that need to be considered in any future development. These include access and transport, existing healthcare facilities, site context, ecology and landscaping and maintaining hospital operations during construction.

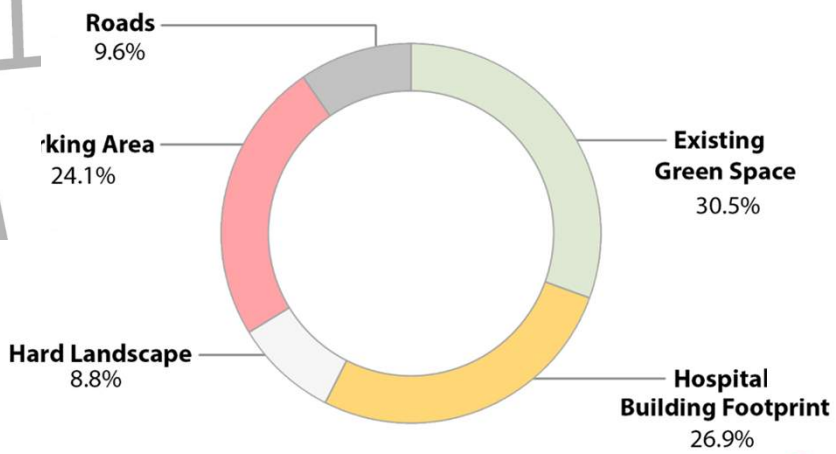


3.2 Pilgrim Hospital Boston Site Analysis

Existing Site Analysis of Land Use:



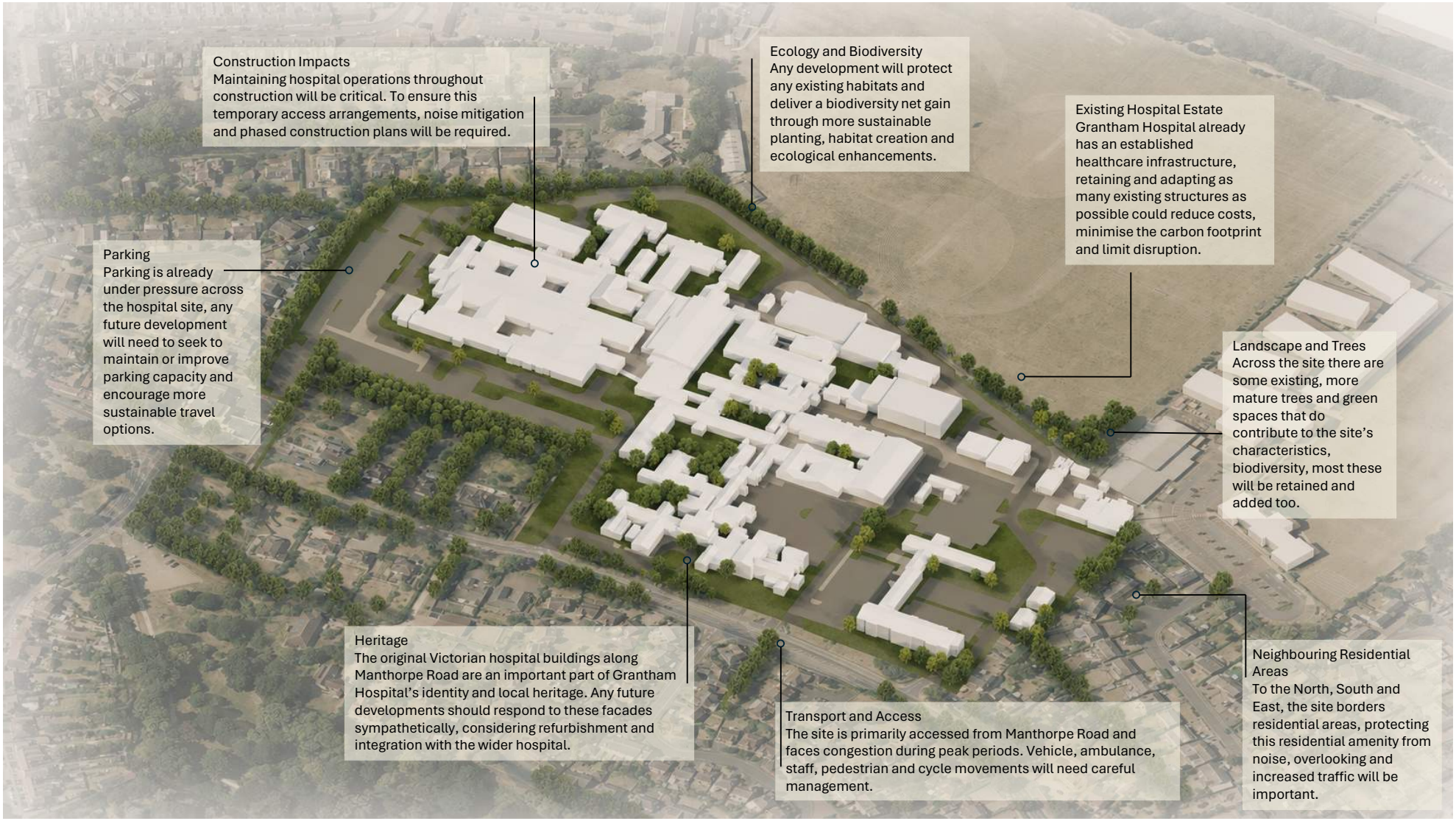




3.3 Grantham and District Hospital Site Analysis

Opportunities, Constraints and Challenges

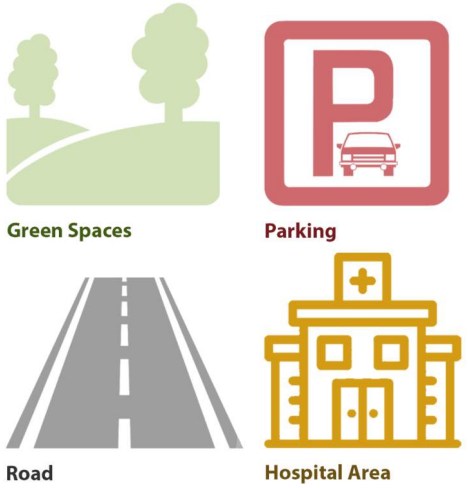
There are a number of opportunities, constraints and challenges that need to be considered prior to beginning the redevelopment of Grantham and District Hospital.

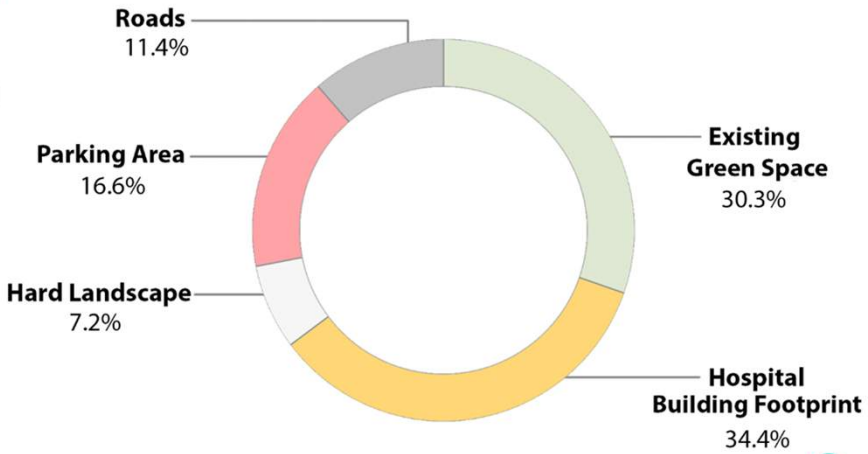


3.3 Grantham and District Hospital Site Analysis

Existing Site Analysis of Land Use:







3.4 Louth County Hospital Site Analysis

Opportunities, Constraints and Challenges

There are a number of opportunities, constraints and challenges that need to be considered prior to beginning the redevelopment of Louth County Hospital.



Construction Impacts
Maintaining uninterrupted healthcare services throughout construction will be a key consideration. A carefully coordinated programme of phased works will help to minimise disruption to patients, visitors and hospital staff.

Ecology and Biodiversity
Redevelopment presents opportunities to increase biodiversity through habitat creation, native planting and sustainable landscape design, delivering long term ecological improvements across the site.

Existing Hospital Estate
Louth County Hospital is an established community healthcare facility supporting a range of outpatient, rehabilitation and diagnostic services. Future investment provides an opportunity to improve the existing estate while making effective use of the current infrastructure and minimising the need for extensive new development.

Parking
The availability of on-site parking is constrained by the existing hospital layout and can become heavily used during peak times but is in good existing condition having been recently resurfaced. Future proposals should seek to improve the efficiency of parking provisions (particularly for staff) whilst maintaining convenient access for staff, patients and visitors.

Landscape and Trees
Existing planting and landscaped spaces contribute positively to the hospital environment. There are significant opportunities to strengthen green improve patient wellbeing and enhance biodiversity through additional planting.

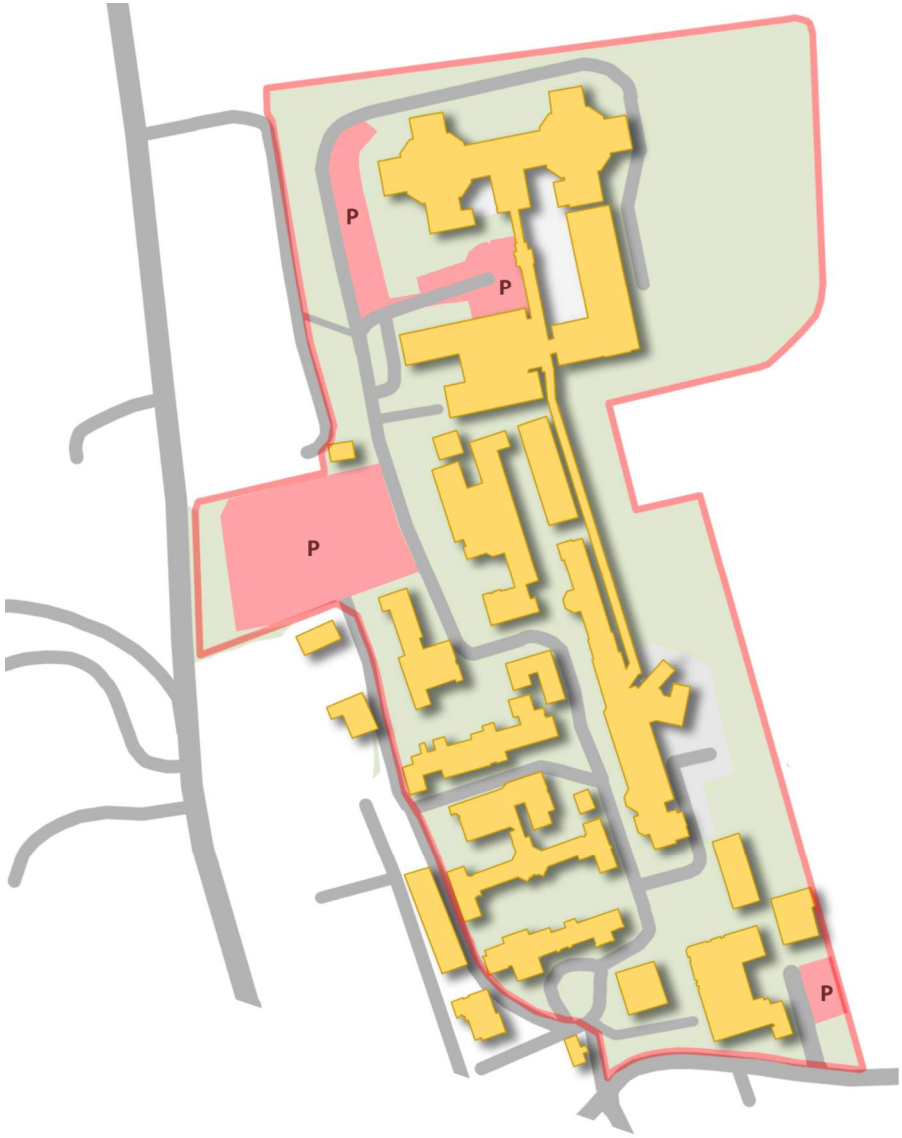
Relationship with the town
The hospital is well integrated within the surrounding urban area and benefits from close links with nearby residential neighbourhoods and local services. Future development should strengthen these connections and encourage active travel

Transport and Access
The hospital is served by the surrounding local road network, accommodating patient, visitor, staff and service vehicle movements. Future proposals should enhance accessibility, improve site circulation and provide a safe arrival for all users.

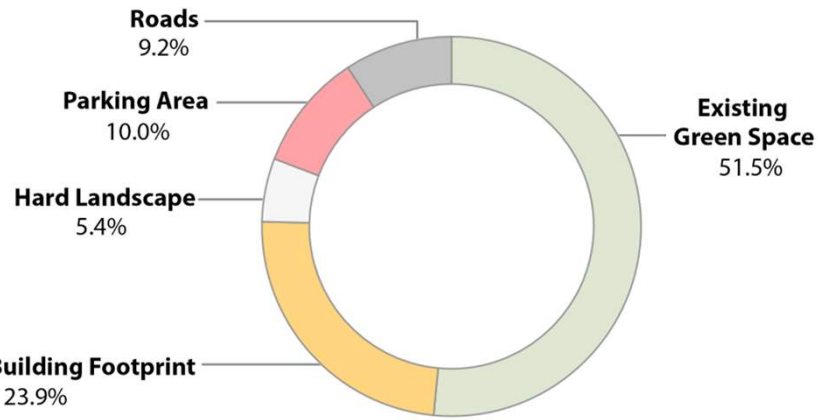
Neighbouring Residential Areas
The hospital is closely bordered by established residential neighbourhoods. Careful consideration should be given to building heights, overlooking, external lighting and construction activities to minimise impacts on surrounding homes

3.4 Louth County Hospital Site Analysis

Existing Site Analysis of Land Use:



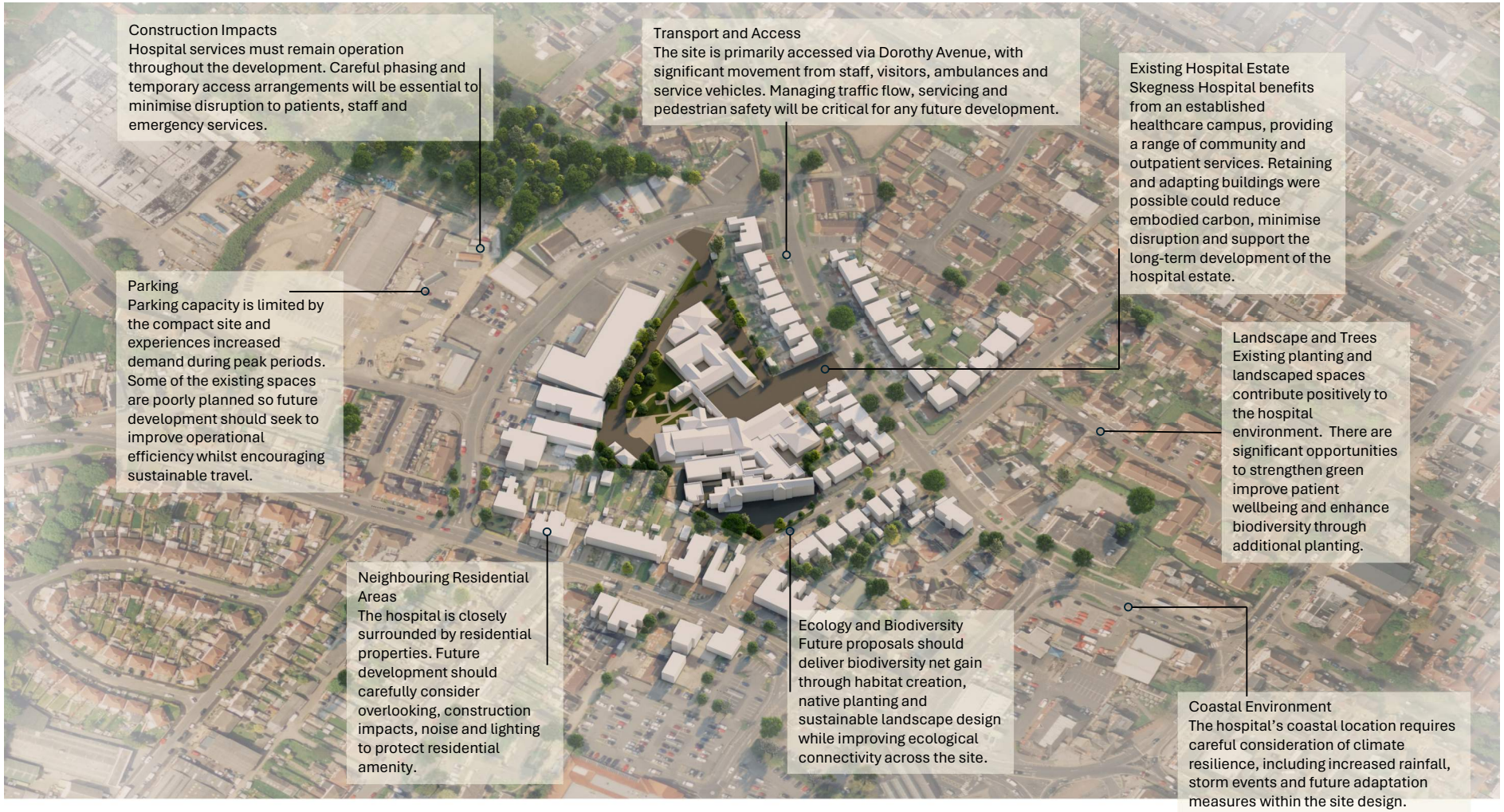




3.5 Skegness Hospital Site Analysis

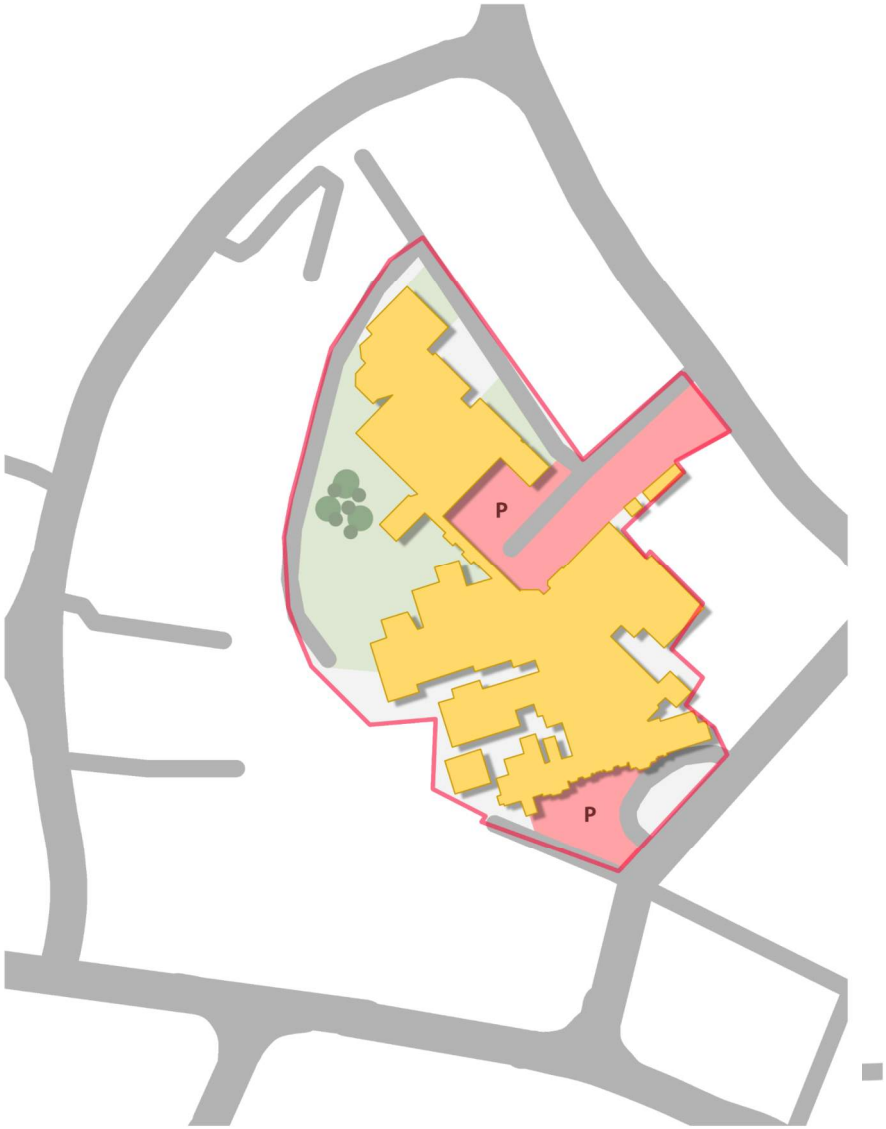
Opportunities, Constraints and Challenges

There are a number of opportunities, constraints and challenges that need to be considered prior to beginning the redevelopment of Skegness Hospital.

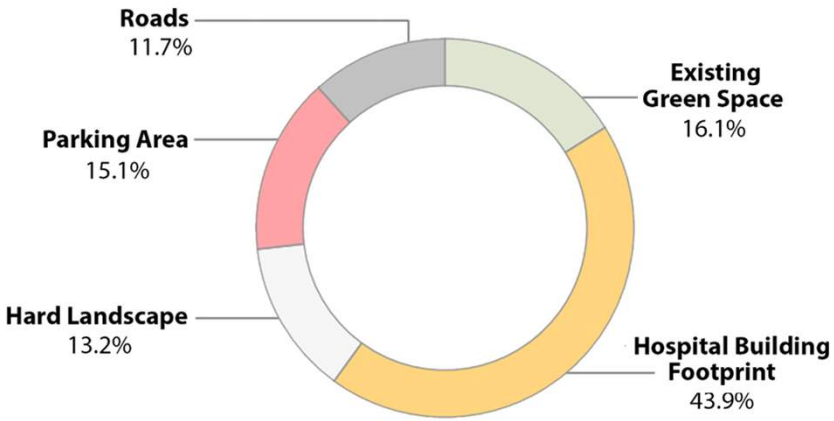


3.5 Skegness Hospital Site Analysis

Existing Site Analysis of Land Use:







3.6 John Coupland Hospital Site Analysis

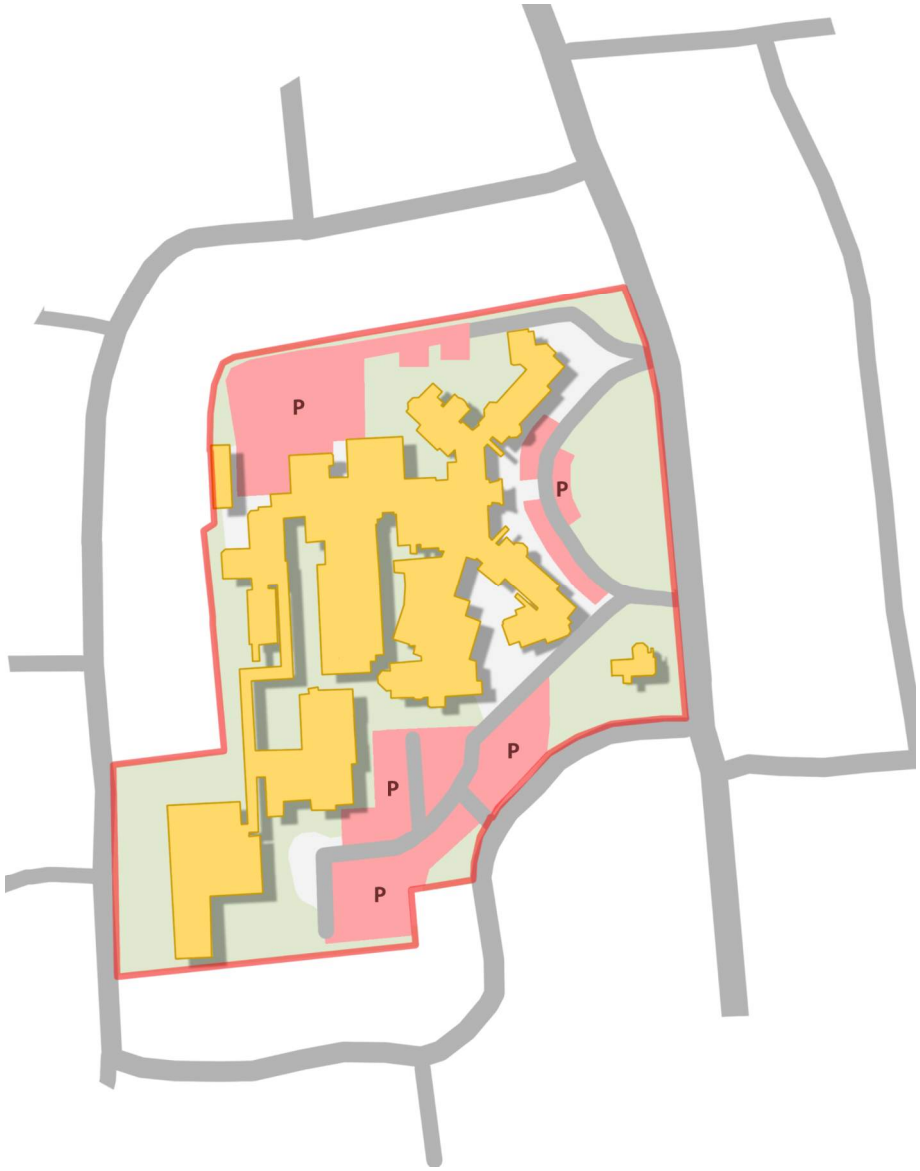
Opportunities, Constraints and Challenges

There are a number of opportunities, constraints and challenges that need to be considered prior to beginning the redevelopment of John Coupland Hospital.

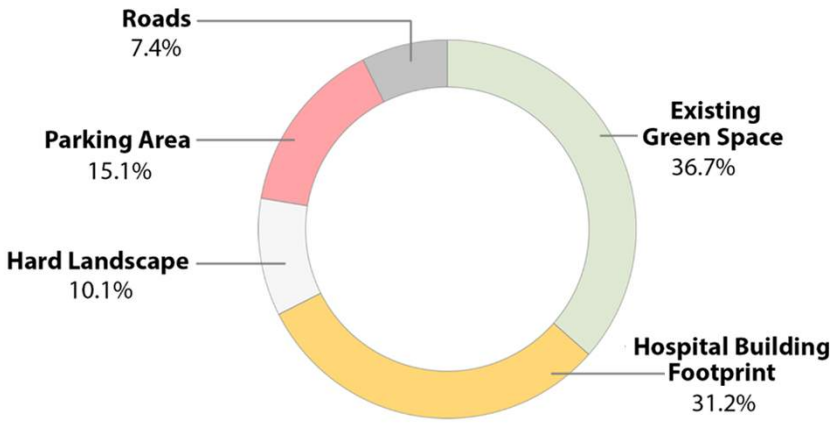


3.6 John Coupland Hospital Site Analysis

Existing Site Analysis of Land Use:







4

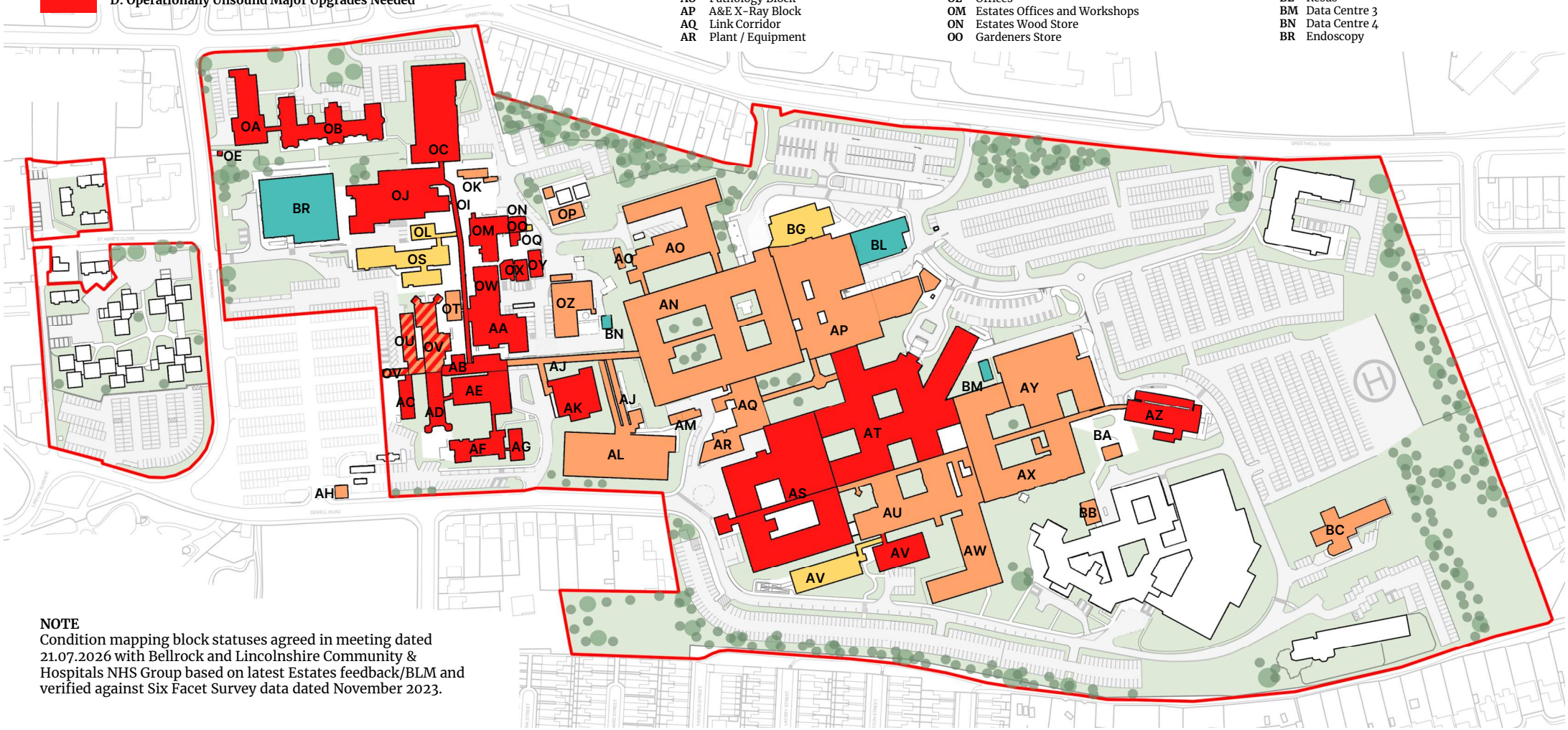
Existing Conditions Plans

2.1 Lincoln County Hospital Existing Conditions Plan

KEY (See Notes Below)

- A: As New
- B: Operationally Safe
- B/C: Structurally/Fabric Rated B but Infrastructure C
- C: Major Repair/Refurb Needed
- C/D: Structurally/Fabric Rated C but Infrastructure D
- D: Operationally Unsound Major Upgrades Needed

AA Facilities Block
AB Hospidea
AC Finance Department
AD Offices
AE Occupational Therapy
AF Creche and Rheumatology Block
AG Rheumatology
AH Switchroom
AJ Link Corridor
AK Physiotherapy
AL 3 Ward Block
AM Pharmacy Medical Gas Store
AN Out Patients Department Block
AO Pathology Block
AP A&E X-Ray Block
AQ Link Corridor
AR Plant / Equipment
AS Ward / Theatre Block
AT Main Entrance, Trust Board Offices & ICU Block
AU, AV.AW, AX Ward Blocks
AY Radiotherapy Block
AZ Endoscopy Unit
OA Staff and Social Block
OB Robey House
OC Maternity Wing
OD MacMillan and Breast Care Nurses
OE Gas Meter Room
OI Maternity Wing Link Corridor
OJ CPU and Social Workers
OK Electrical Switchroom & Med Gas Equipment
OL Offices
OM Estates Offices and Workshops
ON Estates Wood Store
OO Gardeners Store
OP Generator House / Sub-Station
OQ Estates Changing Facilities / Accommodation
OS Breast Screening
OT Offices
OU Old Payroll Block
OV Post Graduate Education Centre and Offices
OW Estates Stores
OY Estates Joiners Workshop
OZ Boiler House Block
BA Generator House 8
BB Energy Centre Block
BC Renal Unit
BG Urgent Treatment Centre
BL Resus
BM Data Centre 3
BN Data Centre 4
BR Endoscopy



NOTE
Condition mapping block statuses agreed in meeting dated 21.07.2026 with Bellrock and Lincolnshire Community & Hospitals NHS Group based on latest Estates feedback/BLM and verified against Six Facet Survey data dated November 2023.

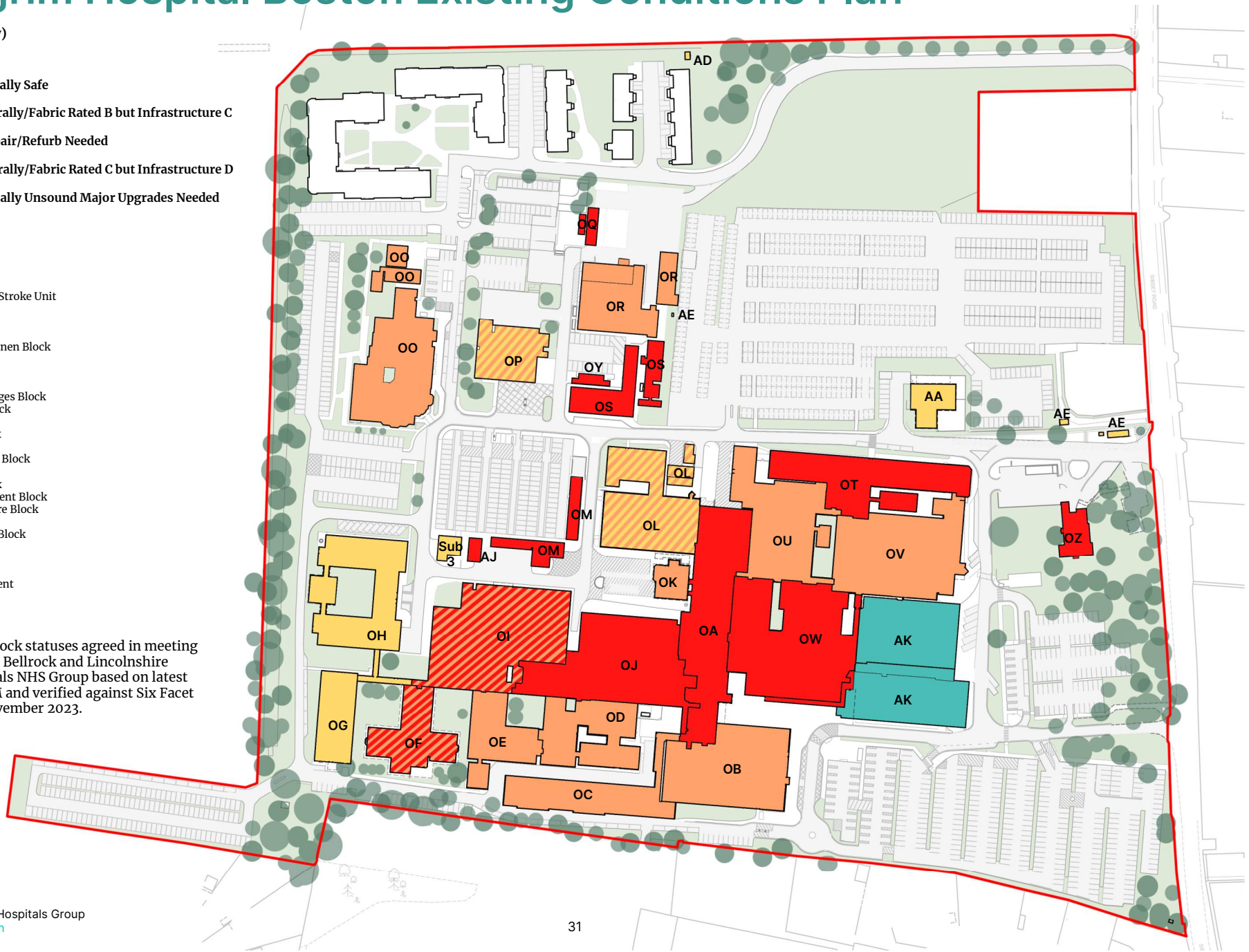
2.2 Pilgrim Hospital Boston Existing Conditions Plan

KEY (See Notes Below)

- **A: As New**
- **B: Operationally Safe**
- **B/C: Structurally/Fabric Rated B but Infrastructure C**
- **C: Major Repair/Refurb Needed**
- **C/D: Structurally/Fabric Rated C but Infrastructure D**
- **D: Operationally Unsound Major Upgrades Needed**

OA Main Tower Block
OB Maternity Block
OC Modular Building
OD Old MDU Block
OE Childrens Clinic, Old Stroke Unit
OF Bostonian Block
OG Ward Block
OH Psychiatry Block
OI Kitchen Stores and Linen Block
OJ Theatre Block
OK Chapel
OL Pathlincs Block
OM Dirty Linen and Garages Block
OO Education Centre Block
OP Ambulance Station
OQ Gardeners Area Block
OR Boiler House Block
OS Estates and Facilities Block
OT Physio and OT Block
OU ENT and X-Ray Block
OV Outpatients Department Block
OW AEC, AMU and Theatre Block
OY Estates
OZ East Skirbeck House Block
AA Day Nursery
AD Pump House Block
AE Meter House Block
AK Emergency Department
AJ Data Centre

NOTE
Condition mapping block statuses agreed in meeting dated 21.07.2026 with Bellrock and Lincolnshire Community & Hospitals NHS Group based on latest Estates feedback/BLM and verified against Six Facet Survey data dated November 2023.

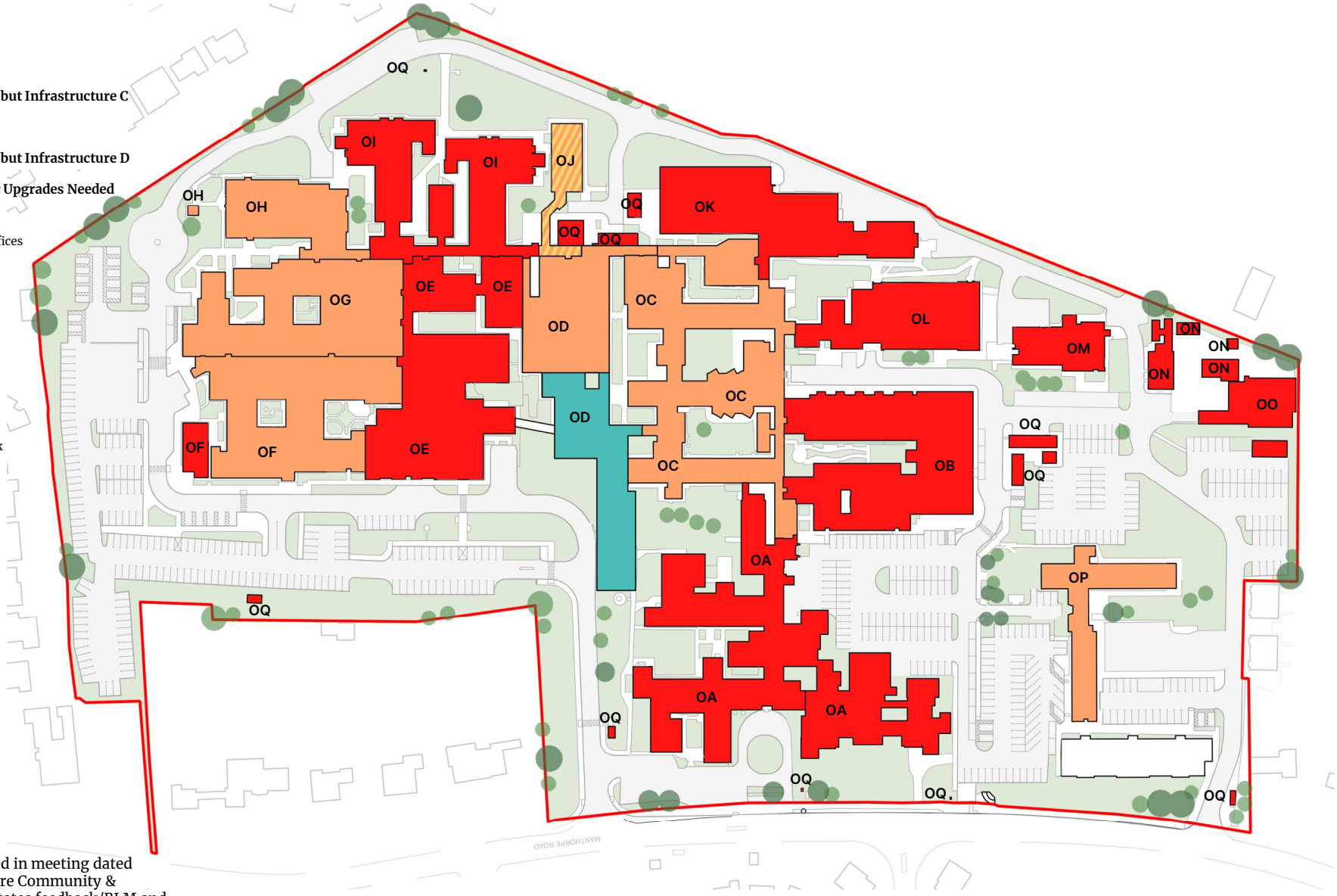


2.3 Grantham and District Hospital Existing Conditions Plan

KEY (See Notes Below)

- **A: As New**
- **B: Operationally Safe**
- **B/C: Structurally/Fabric Rated B but Infrastructure C**
- **C: Major Repair/Refurb Needed**
- **C/D: Structurally/Fabric Rated C but Infrastructure D**
- **D: Operationally Unsound Major Upgrades Needed**

OA Ophthalmology, Training Rooms & Staff Offices
OB Manthorpe Centre (LPFT)
OC Ward and St Barnabas Block
OD Theatre Block
OE A&E, X-Ray and Endoscopy
OF Outpatients Departments
OG Outpatients Departments
OH Outpatients Departments
OI Ward Block
OJ MRI Department
OK Ward, Kitchen and Restaurant Block
OL Tower Block
OM Mortuary and Linen Rooms
ON Old Facilities Offices
OO Old Boiler House Block
OP Facilities Department & Sexual Health Block
OQ Plant Rooms / Water Meters



NOTE
Condition mapping block statuses agreed in meeting dated 21.07.2026 with Bellrock and Lincolnshire Community & Hospitals NHS Group based on latest Estates feedback/BLM and verified against Six Facet Survey data dated November 2023.

2.4 Louth County Hospital Existing Conditions Plan

KEY (See Notes Below)

- **A: As New**
- **B: Operationally Safe**
- **B/C: Structurally/Fabric Rated B but Infrastructure C**
- **C: Major Repair/Refurb Needed**
- **C/D: Structurally/Fabric Rated C but Infrastructure D**
- **D: Operationally Unsound Major Upgrades Needed**

NOTE
Condition mapping block statuses agreed in meeting dated 10.07.2026 with Lincolnshire Community & Hospitals NHS Group based on latest Estates feedback/BLM within the capacity of those in attendance.
Note: Condition statuses have been given as a subjective representation based on historic awareness of the sites only.

SITE NOTES

- Electrical upgrades needed across site (significant risks reported)
- On site VIE is over capacity
- Main block 27 is aged building stock
- Block 8 is Grade II listed in need of extensive refurbishment
- Car park recently resurfaced and in very good condition
- Increase in staff parking would be beneficial

Block 1	Voluntary Car Service
Block 6	Facilities/Hospital Main Reception & Primary Care Clinics
Block 7	Midwives
Block 8	Workhouse Diner
Block 14	Occupational Therapy/Physiotherapy
Block 15	Preston House
Block 16	Estates
Block 17	Laboratory (Blood Test)
Block 19	Pharmacy
Block 21	Outpatient Department
Block 24	MRI Scanner
Block 27	Main Block LG: A-Ray/Theatrs/Ultrasound FF: Fotherby Ward/Pre-Assessment /Musculoskeletal/Ecotech/Dermatology SF: Thoresby Suite/Diabetes/Linen Room
Block 42	Link Corridor
Block 43	Woldside/Urgent Care Centre
Block 44	Endoscopy Unit/Urology Unit
Block 45	Archer Ward/Archer Assessment (Offices)
Block 46	Estates Stores
Block 47	Estates Stores
Block 48	Old Morgue (Vacant)
Block 49	Old Laundry/Store
Block 50	Boiler Room & Stores



2.5 Skegness Hospital Existing Conditions Plan

KEY (See Notes Below)

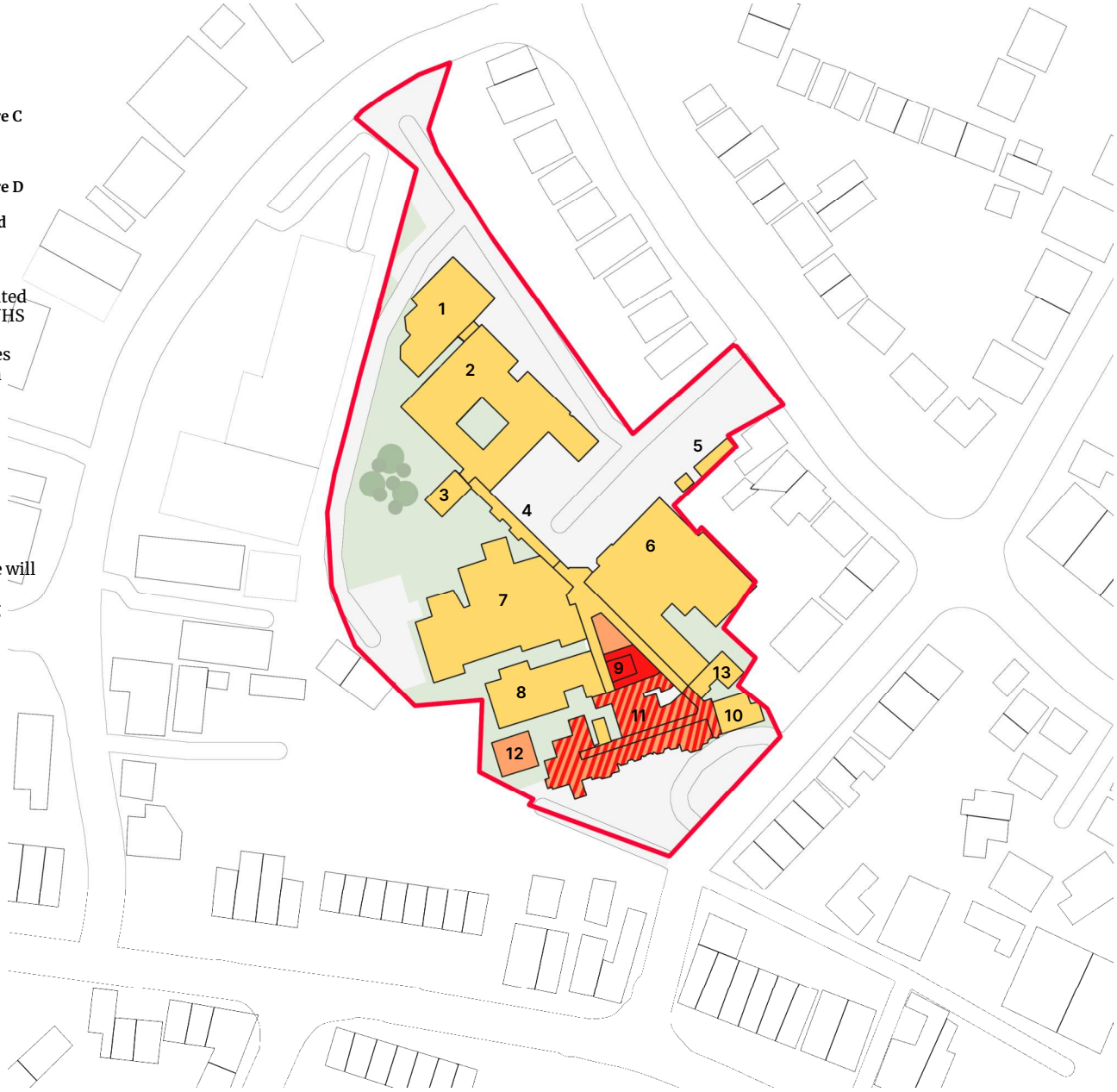
- **A: As New**
- **B: Operationally Safe**
- **B/C: Structurally/Fabric Rated B but Infrastructure C**
- **C: Major Repair/Refurb Needed**
- **C/D: Structurally/Fabric Rated C but Infrastructure D**
- **D: Operationally Unsound Major Upgrades Needed**

NOTE
Condition mapping block statuses agreed in meeting dated 10.07.2026 with Lincolnshire Community & Hospitals NHS Group based on latest Estates feedback/BLM within the capacity of those in attendance. Note: Condition statuses have been given as a subjective representation based on historic awareness of the sites only.

SITE NOTES

- Block 11 is original 1800 building in need of ongoing upgrade & maintenance
- General building stock in good structural condition across site
- Flat roofs across site likely in need of repair and replacement over next 10-20years
- If UTC moves off-site to SDEC, additional floor space will be available
- Car parking provision is good, but space re-planning needed to maximise use

Block 1	Community Day Centre
Block 2	Outpatients (Incl. Occupational Therapy/Physiotherapy)
Block 3	Plant Room & Generator
Block 4	Link Corridor
Block 5	External Store & Bike Shed
Block 6	Scarborough Ward
Block 7	Ward
Block 8	Outpatients
Block 9	Old Store & Couryard
Block 10	Property Services & Facilities Management
Block 11	Urgent Treatment Centre
Block 12	Old Morgue & Stores
Block 13	Oaks Block



2.6 John Coupland Hospital Existing Conditions Plan

KEY (See Notes Below)

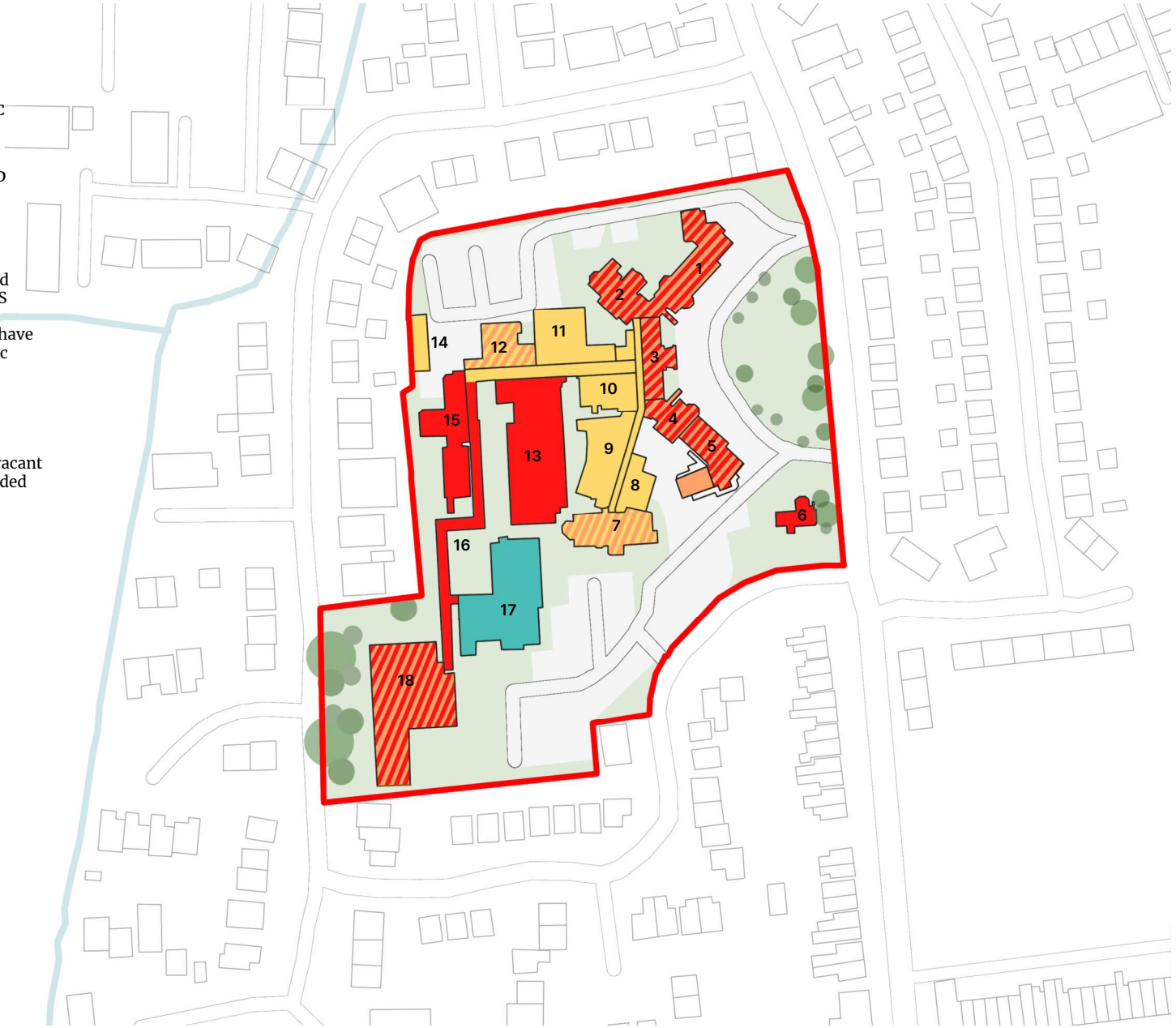
- **A: As New**
- **B: Operationally Safe**
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- **C/D: Structurally/Fabric Rated C but Infrastructure D**
- **D: Operationally Unsound Major Upgrades Needed**

NOTE
Condition mapping block statuses agreed in meeting dated 10.07.2026 with Lincolnshire Community & Hospitals NHS Group based on latest Estates feedback/BLM within the capacity of those in attendance. Note: Condition statuses have been given as a subjective representation based on historic awareness of the sites only.

SITE NOTES

- Blocks 1-5 are part of original 1800 building in need of ongoing upgrade & maintenance
- Approximately 60% of site is underutilised/buildings vacant
- Water & heating issues across site, major upgrades needed
- Car parking is in good repair

Block 1	Theatre Ward
Block 2	Theatre
Block 3	Main Entrance & Waiting
Block 4	Bookable Rooms
Block 5	Stores
Block 6	Vacant Outbuilding
Block 7	Urgent Treatment Centre
Block 8	X-Ray & Ultrasound
Block 9	Outpatient/Bookable Rooms
Block 10	Dining Room
Block 11	Kitchen
Block 12	Plant & Generator
Block 13	Old Scotter Wards (Vacant)
Block 14	Estates Workshop
Block 15	Existing Physiotherapy (Vacant)
Block 16	Link Corridor
Block 17	New Scotter Ward
Block 18	Vacant Block



5

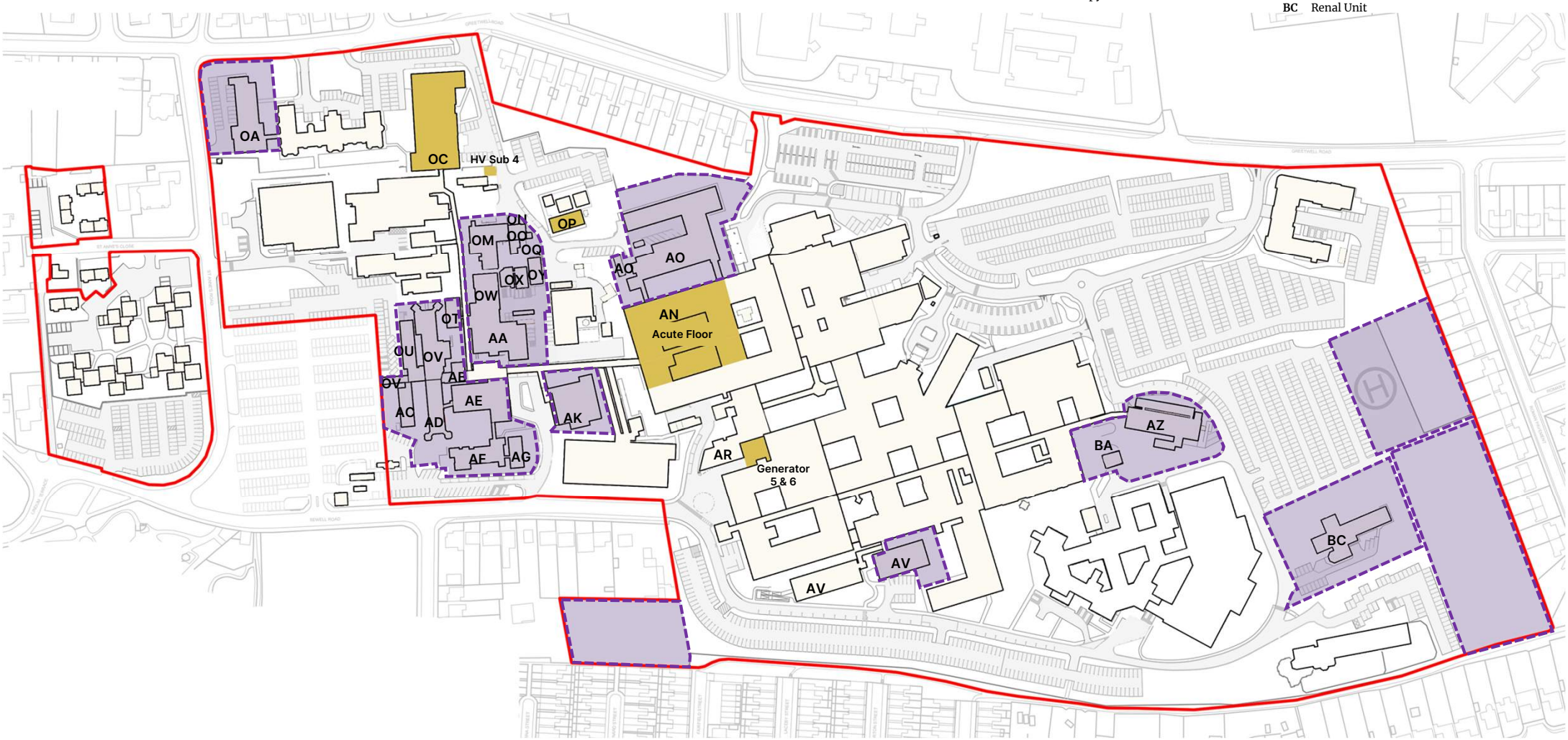
Planned Projects & Potential Development Opportunities

5.1 Lincoln County Hospital Planned Projects & Opportunities

Key

- Planned Capital & BLM Projects
- Potential Areas of Redevelopment

AA Facilities Block
AB Hospidea
AC Finance Department
AD Offices
AE Occupational Therapy
AF Creche and Rheumatology Block
AG Rheumatology
AK Physiotherapy
AN Outpatients Department Block
AO Pathology Block
AR Plant / Equipment
AV Ward Blocks
AZ Endoscopy Unit
OA Staff and Social Block
OC Maternity Wing
OM Estates Offices and Workshops
ON Estates Wood Store
OO Gardeners Store
OP Generator House / Sub-Station
OQ Estates Changing Facilities / Accommodation
OT Offices
OU Old Payroll Block
OV Post Graduate Education Centre and Offices
OW Estates Stores
OY Estates Joiners Workshop
BA Generator House 8
BC Renal Unit

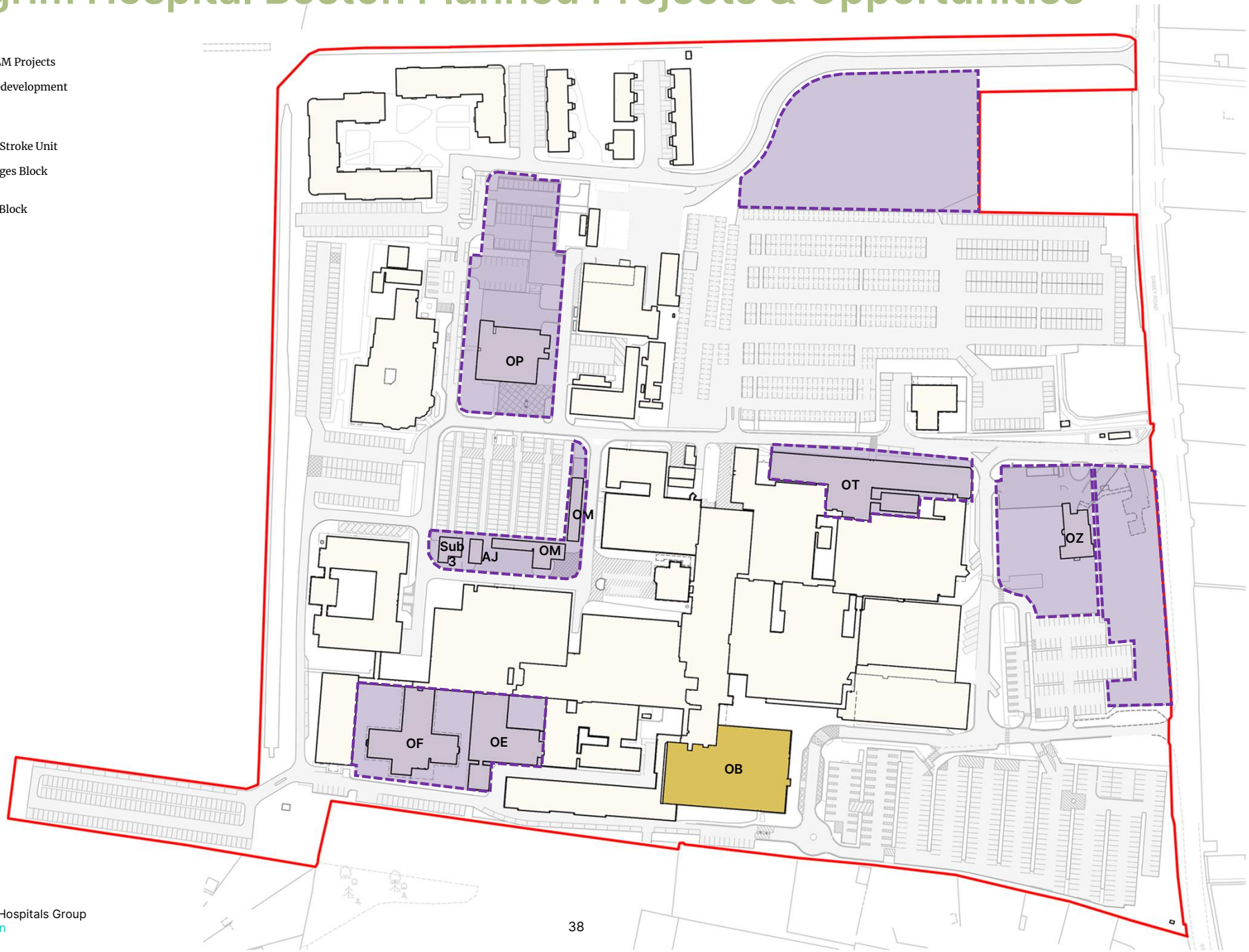


5.2 Pilgrim Hospital Boston Planned Projects & Opportunities

Key

- Planned Capital & BLM Projects
- Potential Areas of Redevelopment

OB Maternity Block
OE Childrens Clinic, Old Stroke Unit
OF Bostonian Block
OM Dirty Linen and Garages Block
OP Ambulance Station
OT Physio and OT Block
OZ East Skirbeck House Block
AJ Data Centre

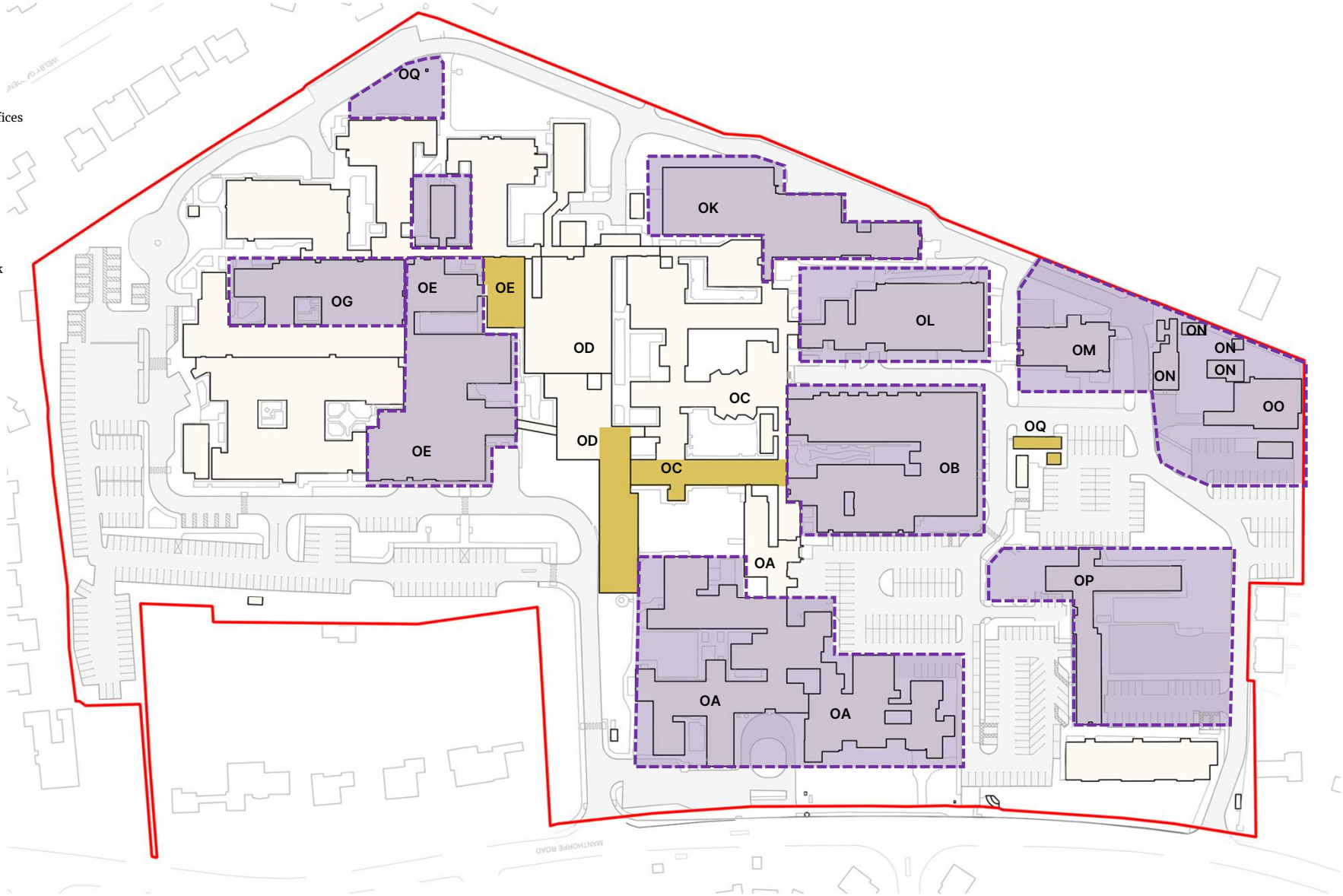


5.3 Grantham and District Hospital Planned Projects & Opportunities

Key

- Planned Capital & BLM Projects
- Potential Areas of Redevelopment

OA Ophthalmology, Training Rooms & Staff Offices
OB Manthorpe Centre (LPFT)
OC Ward and St Barnabas Block
OD Theatre Block
OE A&E, X-Ray and Endoscopy
OG Outpatients Departments
OK Ward, Kitchen and Restaurant Block
OL Tower Block
OM Mortuary and Linen Rooms
ON Old Facilities Offices
OO Old Boiler House Block
OP Facilities Department & Sexual Health Block
OQ Plant Rooms / Water Meters

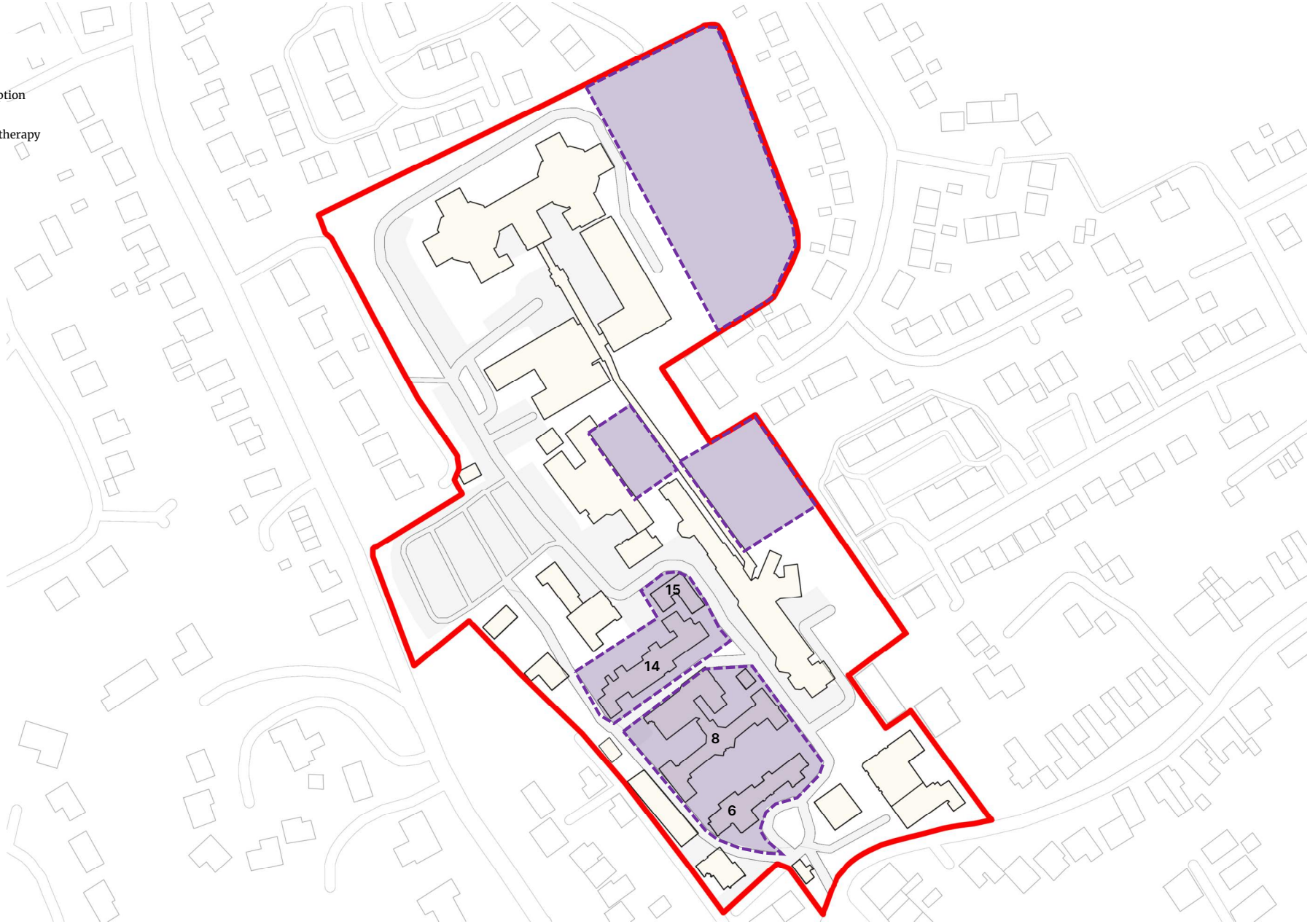


6.4 Louth County Hospital Planned Projects & Opportunities

Key

Potential Areas of Redevelopment

Block 6 Facilities/Hospital Main Reception & Primary Care Clinics
Block 8 Workhouse Diner
Block 14 Occupational Therapy/Physiotherapy
Block 15 Preston House

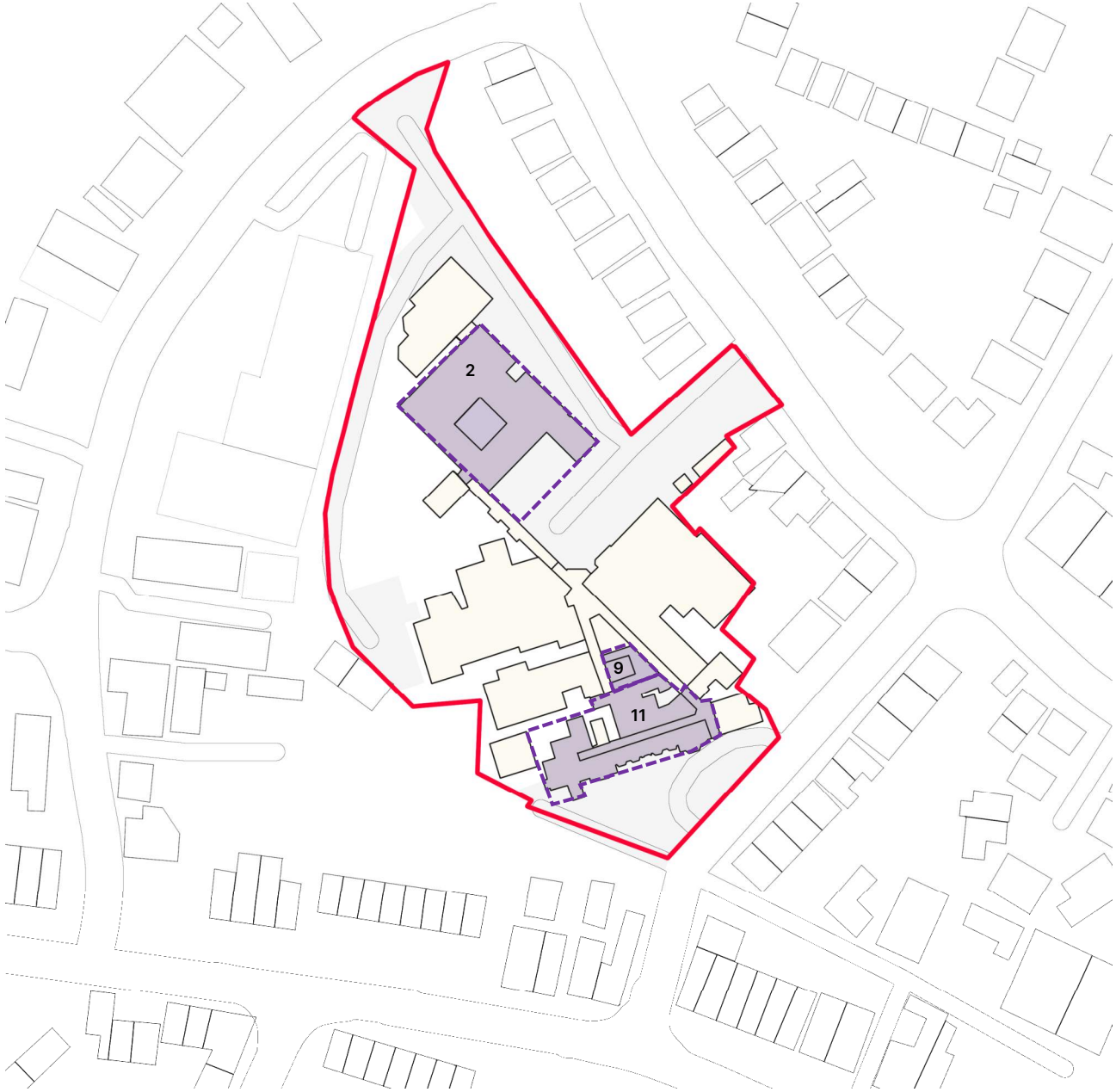


6.5 Skegness Hospital Planned Projects & Opportunities

Key

Potential Areas of Redevelopment

Block 2 Outpatients (Incl. Occupational Therapy/Physiotherapy)
Block 9 Old Store & Couryard
Block 11 Urgent Treatment Centre

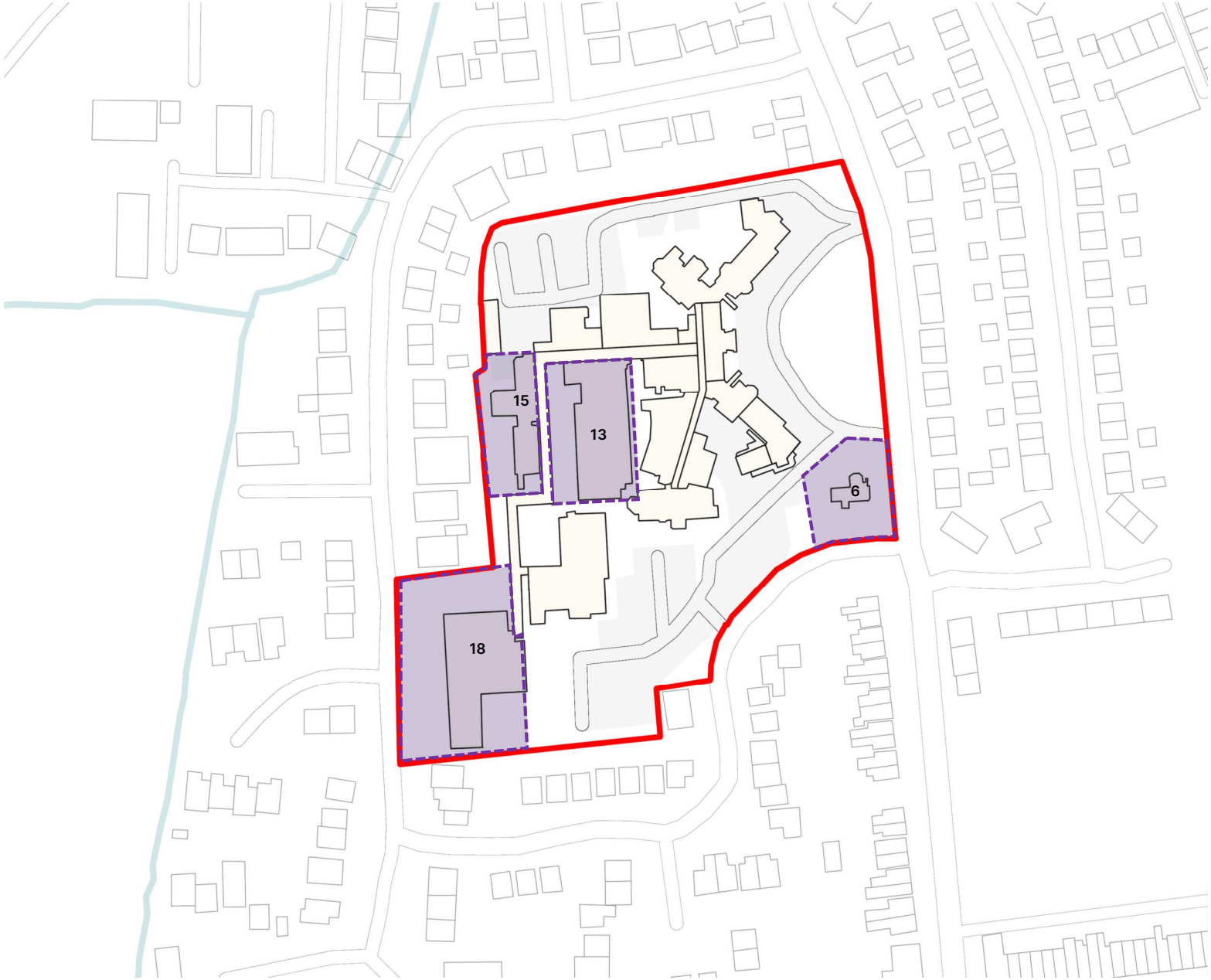


6.6 John Coupland Hospital Planned Projects & Opportunities

Key

Potential Areas of Redevelopment

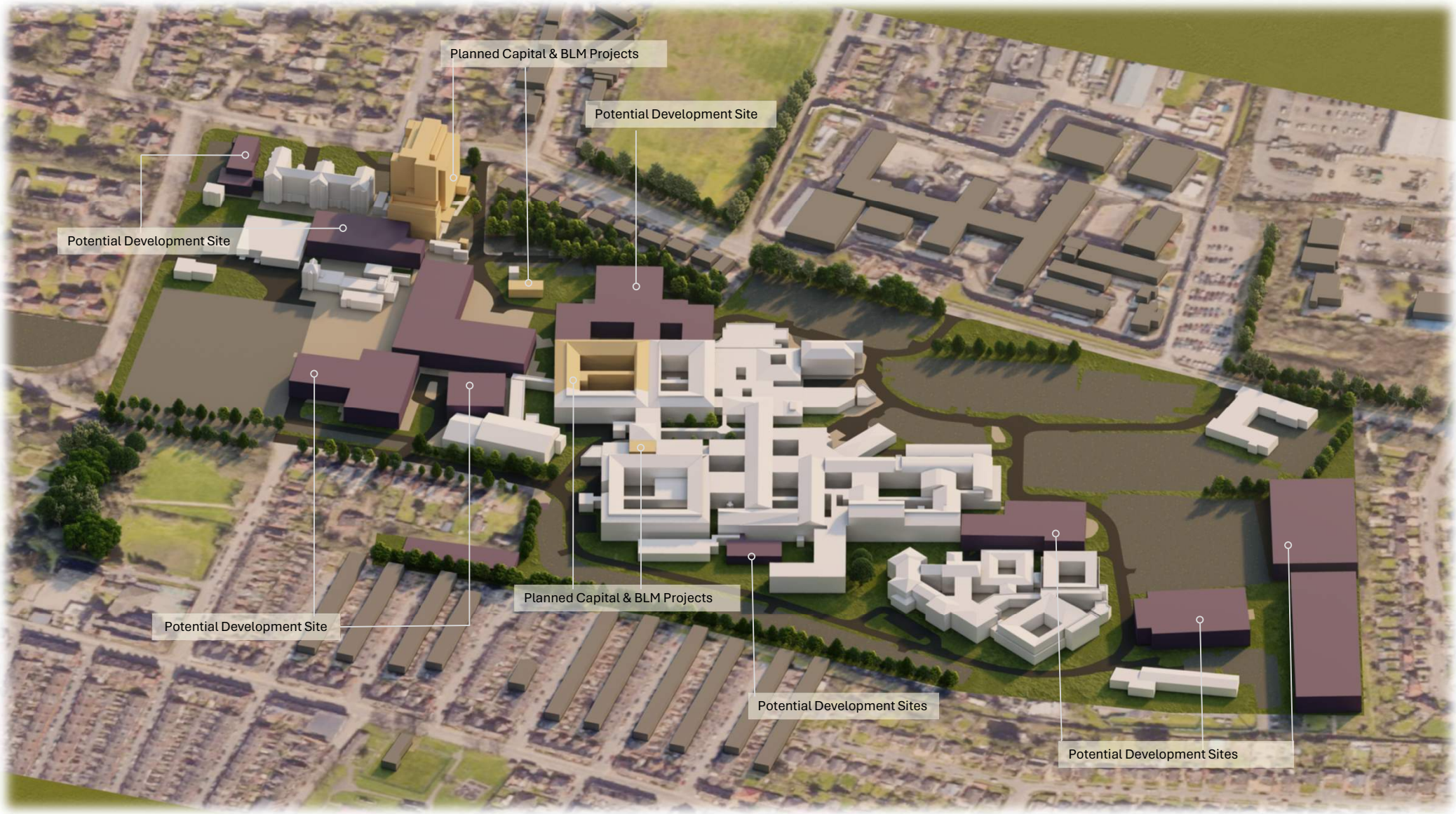
Block 6 Vacant Outbuilding
Block 13 Old Scotter Wards (Vacant)
Block 15 Existing Physiotherapy (Vacant)
Block 18 Vacant Block



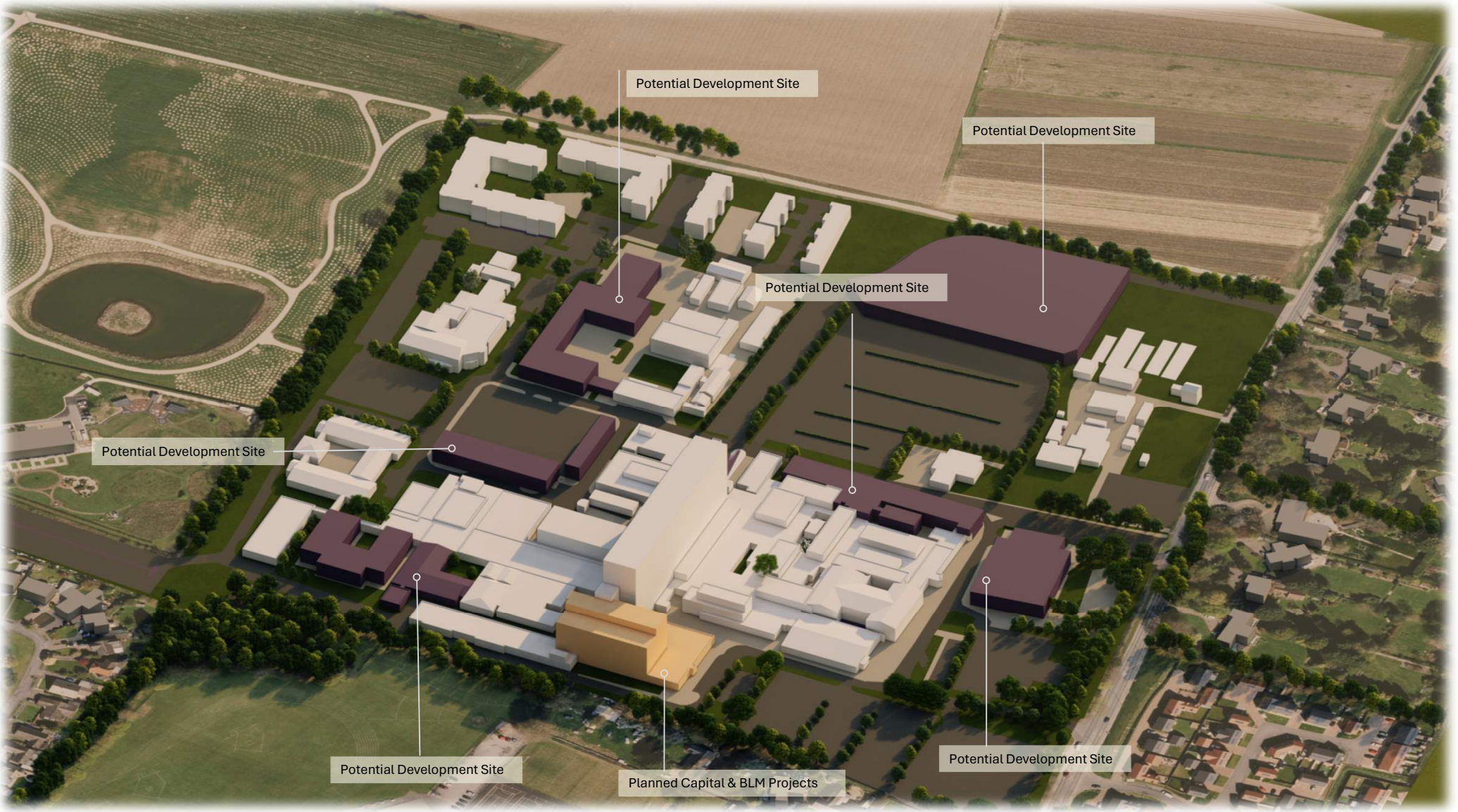
6

5-10 Year Potential Development Sites

6.1 Lincoln County Hospital Potential Development Sites



6.2 Pilgrim Hospital Boston Potential Development Sites



6.3 Grantham & District Hospital Potential Development Sites



6.4 Louth County Hospital Potential Development Sites



6.5 Skegness Hospital Potential Development Sites



6.6 John Coupland Hospital Potential Development Sites





The Cruck Barn
Duxbury Park
Chorley
Lancashire
PR74AT

01257 260070

contact@gillingdod.com
www.gillingdod.com

Model Health System

United Lincolnshire Hospitals NHS Trust

Estates & Facilities

Report Date: 07 October 2026

Generated by: Amanda Brown

The Model Hospital website: https://model.nhs.uk

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Trust Summary

Presents summary metrics on sites, space, PFI space and number of beds

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Site Summary	Data period	Provider value	Peer median	Provider median	Chart
Total number of sites (No.)	2024/25	106	19	29	
Number of sites reported in ERIC (No.)	2024/25	32	14	20	
Number of sites not reported ERIC (No.)	2024/25	74	3	5	

Area	Data period	Provider value	Peer median	Provider median	Chart
Gross internal area (m2)	2024/25	171.04k	182.33k	102.55k	
Occupied floor area (m2)	2024/25	163.93k	168.97k	94,350	

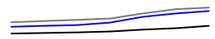
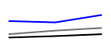
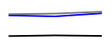
PFI Area	Data period	Provider value	Peer median	Provider median	Chart
PFI Occupied floor area (m2)	2022/23	0	8,337	0	
Percentage PFI occupied floor area (%)	2024/25	0.0%	5.0%	0.0%	

Organisation Level

Compare efficiency, productivity, quality and safety for estates and facilities management. Benchmark values are medians of the pre-set Estates peer group.

Data period: latest available at the time of generating this report

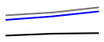
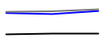
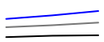
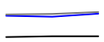
Peer group: 'My Peers - Estates & Facilities'

Cost of Occupancy	Data period	Provider value	Peer average	National value	National value method	Chart
Estates & Facilities cost (£ per m2)	2024/25	£538.53/m2	£580.42/m2	£507.91/m2	Provider median	
• Occupancy cost (£)	2024/25	£88.28m	£96.80m	£51.80m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Estates & Facilities cost (£ per WAU)	2024/25	£500.78	£496.34	£500.95	Provider median	
• Estates and facilities cost (£)	2024/25	£88.28m	£96.80m	£78.71m	Provider median	
• Weighted Activity Unit	2024/25	176.28k	180.13k	156.86k	Provider median	
Management (hard and soft FM) costs (£/m2)	2024/25	£15.11/m2	£11.22/m2	£10.23/m2	Provider median	
• Management (hard and soft FM) costs (£)	2024/25	£2.48m	£1.52m	£1.06m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Finance cost (£/m2)	2024/25	£132.27/m2	£209.23/m2	£204.57/m2	Provider median	∅ No chart available
• Finance cost (£)	2024/25	£21.68m	£35.85m	£19.95m	Provider median	∅ No chart available

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

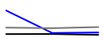
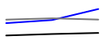
Model Health System

Cost of Occupancy	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied floor area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	∅ No chart available

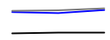
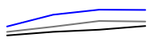
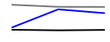
Hard Facilities Management Costs	Data period	Provider value	Peer average	National value	National value method	Chart
Hard FM cost (£ per m2)	2024/25	£157.27/m2	£164.31/m2	£128.85/m2	Provider median	
• Total Hard FM cost (£)	2024/25	£25.78m	£28.27m	£12.44m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Hard FM cost (£ per WAU)	2024/25	£146.25	£136.69	£135.62	Provider median	
• Hard FM cost (£)	2024/25	£25.78m	£28.27m	£20.81m	Provider median	
• Weighted Activity Unit	2024/25	176.28k	180.13k	156.86k	Provider median	
Estates & property maintenance (£ per m2)	2024/25	£83.11/m2	£51.99/m2	£46.06/m2	Provider median	
• Estates & property maintenance cost (£)	2024/25	£13.62m	£9.34m	£4.66m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Grounds and gardens maintenance (£ per m2)	2024/25	£0.10/m2	£1.34/m2	£1.23/m2	Provider median	
• Grounds and gardens maintenance cost (£)	2024/25	£15,887	£271.90k	£125.42k	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
EBME Costs (£/m2)	2024/25	£0.00/m2	£30.93/m2	£13.83/m2	Provider median	
• EBME cost (£)	2024/25	£0	£4.88m	£1.46m	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Hard Facilities Management Costs	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Car parking services cost (£/space)	2024/25	£77.67	£204.55	£94.58	Provider median	
• Car parking service cost (£)	2024/25	£305.33k	£640.14k	£161.40k	Provider median	
• Total car parking spaces available (No.)	2024/25	3,931	3,334	1,940	Provider median	
Water & sewage cost (£ per m2)	2024/25	£7.46/m2	£5.37/m2	£4.19/m2	Provider median	
• Water & sewage cost (£)	2024/25	£1.22m	£872.84k	£392.12k	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.65km2	168.27km2	94,350m2	Provider median	
Total energy cost (£ per kWh)	2024/25	£0.0993	£0.1139	£0.1229	Provider median	
• Total energy cost (£)	2024/25	£8.48m	£7.82m	£4.13m	Provider median	
• Total energy consumed (kWh)	2024/25	85.42m	76.22m	36.69m	Provider median	
Total waste cost (£/tonne)	2024/25	£642.61	£465.89	£465.21	Provider median	
• Total Waste cost (£)	2024/25	£1.80m	£1.28m	£622.45k	Provider median	
• Total Waste volume (Tonnes)	2024/25	2,802.03	2,627.32	1,365.10	Provider median	

Soft Facilities Management Costs	Data period	Provider value	Peer average	National value	National value method	Chart
Soft FM cost (£ per m2)	2024/25	£233.89/m2	£191.52/m2	£162.42/m2	Provider median	
• Total Soft FM cost (£)	2024/25	£38.34m	£29.76m	£15.87m	Provider median	

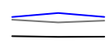
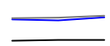
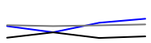
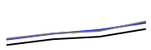
Soft Facilities Management Costs	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Soft (FM) cost (£ per WAU)	2024/25	£217.49	£166.91	£170.29	Provider median	
• Soft FM cost	2024/25	£38.34m	£29.76m	£26.47m	Provider median	
• Weighted Activity Unit	2024/25	176.28k	180.13k	156.86k	Provider median	
Cleaning cost (£ per m2)	2024/25	£75.60/m2	£60.08/m2	£58.03/m2	Provider median	
• Cleaning service cost (£)	2024/25	£12.39m	£10.45m	£5.71m	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.93km2	168.01km2	94,350m2	Provider median	
Food cost (£ per Meal)	2024/25	£2.64	£5.50	£5.85	Provider median	
• Inpatient food cost (£)	2024/25	£3.39m	£5.15m	£3.67m	Provider median	
• Inpatient main meals requested (No.)	2024/25	1.28m	978.30k	650.87k	Provider median	
Laundry & linen cost (£ per Item)	2024/25	£0.60	£0.44	£0.48	Provider median	
• Laundry & linen cost (£)	2024/25	£2.28m	£1.99m	£928.34k	Provider median	
• Laundered pieces per annum (No.)	2024/25	3.78m	4.39m	2.12m	Provider median	
Laundry cost (£/Item)	2023/24	£0.06	£0.36	£0.35	Provider median	
• Laundry cost (£)	2023/24	£233.37k	£1.40m	£350.47k	Provider median	
• Laundered pieces per annum (No.)	2023/24	4.15m	3.71m	1.97m	Provider median	

Soft Facilities Management Costs	Data period	Provider value	Peer average	National value	National value method	Chart
Linen cost (£)	2023/24	£76,989	£324.35k	£189.19k	Provider median	
Portering (£ per m2)	2024/25	£10.95/m2	£21.21/m2	£18.40/m2	Provider median	
• Portering service cost (£)	2024/25	£1.80m	£3.19m	£2.13m	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.93km2	168.97km2	104.63km2	Provider median	

Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
Occupied floor area (m2 per WAU)	2024/25	0.93	0.87	0.91	Provider median	
• Occupied floor area (m2)	2024/25	163.93km2	168.97km2	142.70km2	Provider median	
• Weighted Activity Unit	2024/25	176.28k	180.13k	156.86k	Provider median	
Cleaning productivity (m2 per WTE)	2024/25	537.10	582.22	611.61	Provider median	
• Relevant Occupied floor area (m2)	2024/25	163.93km2	168.01km2	94,350m2	Provider median	
• Cleaning staff (WTE)	2024/25	305.21	284.86	159.46	Provider median	
Laundry & linen productivity (Items per WAU)	2024/25	21.44	24.76	24.27	Provider median	
• Laundry and linen pieces per annum	2024/25	3.78m	4.34m	3.73m	Provider median	
• Weighted Activity Unit	2024/25	176.28k	180.13k	156.86k	Provider median	
Energy costs per m² (£/m²)	2024/25	£51.76/m2	£50.56/m2	£45.65/m2	Provider median	
• Total Energy costs (£)	2024/25	£8.48m	£7.82m	£4.13m	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Energy consumption per m² (kWh per m²)	2024/25	521.10	456.66	391.90	Provider median	
• Total energy consumed (kWh)	2024/25	85.42m	76.22m	36.69m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Waste productivity (Kg per WAU)	2024/25	15.89	14.80	15.01	Provider median	
• Waste (Kg)	2024/25	2.80m	2.63m	2.26m	Provider median	
• Weighted Activity Unit	2024/25	176.28k	180.13k	156.86k	Provider median	

Quality	Data period	Provider value	Peer median	Provider median	Chart
Cleanliness - Patient Led Assessment Score	2025	99.5%	98.6%	99.2%	
Food - Patient Led Assessment Score	2025	89.5%	92.0%	92.9%	
Privacy, Dignity & Wellbeing - Patient Led Assessment Score	2025	90.8%	84.5%	91.1%	
Condition, Appearance & Maintenance - Patient Led Assessment Score	2025	97.5%	97.2%	97.7%	
Dementia Environment - Patient Led Assessment Score	2025	84.9%	84.2%	88.5%	
Disability - Patient Led Assessment Score	2025	89.2%	85.5%	89.2%	

Backlog Maintenance

Overview of the backlog position and the investment in it

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Cost to Eradicate Backlog Maintenance	Data period	Provider value	Peer average	National value	National value method	Chart
Total backlog maintenance costs (£)	2024/25	£126.06m	£68.63m	£43.74m	Provider median	
Total backlog maintenance (£ per m2)	2024/25	£771.22/m2	£475.06/m2	£430.65/m2	Provider median	
• Total backlog maintenance cost (£)	2024/25	£126.06m	£68.63m	£43.74m	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.45km2	168.97km2	94,226m2	Provider median	

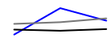
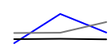
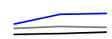
Critical Infrastructure Risk	Data period	Provider value	Peer average	National value	National value method	Chart
Total critical infrastructure risk (£)	2024/25	£48.24m	£38.86m	£17.96m	Provider median	
CIR as a percentage of total backlog mainenance (%)	2024/25	38.26%	51.90%	48.24%	Provider median	
• Critical infrastructure risk backlog maintenance cost (£)	2024/25	£48.24m	£38.86m	£18.11m	Provider median	
• Total backlog maintenance cost (£)	2024/25	£126.06m	£68.63m	£43.99m	Provider median	
Critical infrastructure risk (£ per m2)	2024/25	£295.10/m2	£217.97/m2	£186.38/m2	Provider median	
• Critical infrastructure risk backlog cost (£)	2024/25	£48.24m	£38.86m	£17.96m	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.45km2	168.97km2	94,226m2	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Non-Critical Infrastructure Risk	Data period	Provider value	Peer average	National value	National value method	Chart
Total non-critical infrastructure risk (£)	2024/25	£77.82m	£35.10m	£19.49m	Provider median	
Non CIR as a percentage of total backlog mainenance (%)	2024/25	61.74%	48.10%	51.76%	Provider median	
• Non-Critical infrastructure risk backlog maintenance cost (£)	2024/25	£77.82m	£35.10m	£20.24m	Provider median	
• Total backlog maintenance cost (£)	2024/25	£126.06m	£68.63m	£43.99m	Provider median	
Non critical infrastructure risk (£ per m2)	2024/25	£476.11/m2	£251.38/m2	£190.70/m2	Provider median	
• Non-Critical infrastructure risk backlog maintenance cost (£)	2024/25	£77.82m	£35.10m	£19.49m	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.45k	168.97k	94,226	Provider median	

Investment in Backlog Maintenance	Data period	Provider value	Peer average	National value	National value method	Chart
Investment to reduce backlog maintenance	2024/25	£5.63m	£6.46m	£2.41m	Provider median	
Investment to reduce backlog maintenance - Critical infrastructure risk (£)	2024/25	£2.92m	£5.51m	£1.22m	Provider median	
Investment to reduce backlog maintenance - Non critical infrastructure risk (£)	2024/25	£2.70m	£1.19m	£606.87k	Provider median	
Investment to reduce backlog maintenance (£ per m2)	2024/25	£34.41/m2	£42.06/m2	£26.29/m2	Provider median	
• Investment to reduce backlog maintenance (£)	2024/25	£5.63m	£6.46m	£2.41m	Provider median	
• Relevant occupied floor area (m2)	2024/25	163.45km2	168.97km2	94,226m2	Provider median	
Investment to reduce backlog maintenance as a % of total backlog maintenance (%)	2024/25	4.46%	7.91%	5.79%	Provider median	

Investment in Backlog Maintenance	Data period	Provider value	Peer average	National value	National value method	Chart
• Investment to reduce backlog maintenance (£)	2024/25	£5.63m	£6.46m	£2.51m	Provider median	
• Total backlog maintenance cost (£)	2024/25	£126.06m	£68.63m	£43.99m	Provider median	
Investment to reduce backlog maintenance - Critical infrastructure risk (£) as a % of CIR	2024/25	6.05%	12.58%	6.51%	Provider median	
• Investment to reduce backlog maintenance - Critical infrastructure risk (£)	2024/25	£2.92m	£5.51m	£1.25m	Provider median	
• Critical infrastructure risk backlog cost (£)	2024/25	£48.24m	£38.86m	£18.35m	Provider median	
Investment to reduce backlog maintenance - Non-Critical infrastructure risk (£) as a % of Non CIR	2024/25	3.48%	3.52%	3.48%	Provider median	
• Investment to reduce backlog maintenance - Non-Critical infrastructure risk (£)	2024/25	£2.70m	£1.19m	£638.01k	Provider median	
• Non-critical infrastructure risk backlog cost (£)	2024/25	£77.82m	£35.10m	£20.35m	Provider median	

Space Usage

This sub-compartment presents metrics relating to how trusts use the estate.

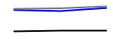
Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Space Overview	Data period	Provider value	Peer average	National value	National value method	Chart
Occupied floor area (m2)	2024/25	163.93k	168.97k	94,350	Provider median	
Amount of empty space (%)	2024/25	4.90%	0.05%	0.01%	Provider median	
• Empty space (m2)	2024/25	8,034m2	78m2	15m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Amount of under-utilised space (%)	2024/25	0.78%	0.01%	0.00%	Provider median	
• Under-utilised space (m2)	2024/25	1,280m2	18m2	2m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Percentage of land not delivering services (%)	2024/25	0.00%	2.29%	0.00%	Provider median	
• Land area not delivering services (Hectares)	2024/25	0.00	0.57	0.00	Provider median	
• Land area owned (Hectares)	2024/25	46.27	30.73	20.24	Provider median	
Ratio of land owned to occupied floor area (m2/m2)	2024/25	2.82	1.78	1.83	Provider median	
• Land area owned (m2)	2024/25	462.70km2	307.25km2	202.40km2	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

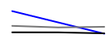
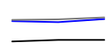
Space Overview	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	

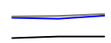
Space usage - Clinical	Data period	Provider value	Peer average	National value	National value method	Chart
Amount of clinical space (%)	2024/25	71.26%	66.57%	67.90%	Provider median	
• Total clinical space (m2)	2024/25	116.81km2	109.28km2	70,941m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Clinical sterile services department space (%)	2024/25	0.73%	0.66%	0.26%	Provider median	
• Clinical sterile services department space (m2)	2024/25	1,196m2	1,138m2	399m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Pathology space (%)	2024/25	0.57%	2.41%	1.62%	Provider median	
• Pathology space (m2)	2024/25	940m2	4,228m2	1,667m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Private patient space (%)	2024/25	0.00%	0.00%	0.00%	Provider median	
• Private patient space (m2)	2024/25	0m2	0m2	0m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Clinical Space - Other (%)	2024/25	69.95%	63.61%	64.93%	Provider median	
• Clinical space - other (m2)	2024/25	114.67km2	104.45km2	65,979m2	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Space usage - Clinical	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	

Space usage - Non-clinical	Data period	Provider value	Peer average	National value	National value method	Chart
Amount of non-clinical space (%)	2024/25	28.74%	33.43%	32.10%	Provider median	
• Non-clinical space (m2)	2024/25	47,119m2	51,628m2	33,414m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
General administration space (%)	2024/25	3.58%	6.64%	5.36%	Provider median	
• General administration space (m2)	2024/25	5,870m2	11,684m2	5,641m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Human resources space (%)	2024/25	0.21%	0.34%	0.34%	Provider median	
• Human resources space (m2)	2024/25	351m2	521m2	360m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Information technology space (%)	2024/25	0.44%	0.74%	0.72%	Provider median	
• Information technology space (m2)	2024/25	726m2	1,256m2	745m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Medical records space (%)	2024/25	1.04%	1.10%	0.66%	Provider median	
• Medical records space (m2)	2024/25	1,698m2	1,677m2	631m2	Provider median	

Space usage - Non-clinical	Data period	Provider value	Peer average	National value	National value method	Chart
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Restaurants space (%)	2024/25	1.04%	0.89%	0.73%	Provider median	
• Restaurants space (m2)	2024/25	1,708m2	1,553m2	853m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Staff accommodation (%)	2024/25	0.00%	0.95%	0.47%	Provider median	
• Staff accommodation (m2)	2024/25	0m2	1,599m2	469m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	
Non - Clinical Space - Other (%)	2024/25	22.43%	21.53%	20.03%	Provider median	
• Non-clinical space - other (m2)	2024/25	36,766m2	33,423m2	20,954m2	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	99,736m2	Provider median	

Safety and Accessibility

Safety

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Fires	Data period	Provider value	Peer median	Provider median	Chart
Fires recorded (No.)	2024/25	2	3	2	
Injuries resulting from fires (No.)	2024/25	0	0	0	
Deaths resulting from fires (No.)	2024/25	0	0	0	

Clinical Service Incidents	Data period	Provider value	Peer average	National value	National value method	Chart
Total Clinical service incidents caused by estates and infrastructure failure	2024/25	0	2	1	Provider median	
• Critical Infrastructure Risk - E&F clinical service incidents	2024/25	0	1	0	Provider median	
• Non-Critical Infrastructure Risk - E&F clinical service incidents	2024/25	0	0	0	Provider median	
• Other - E&F clinical service incidents	2024/25	0	1	0	Benchmark value	

Safety Incidents	Data period	Provider value	Peer median	Provider median	Chart
Estates and facilities RIDDOR incidents (No)	2024/25	3	3	1	
Number of estates and facilities related incidents (No.)	2024/25	0	4	2	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Safety Incidents	Data period	Provider value	Peer median	Provider median	Chart
Number of estates and facilities related incidents related to Critical Infrastructure Risk	2024/25	0	0	0	
Number of estates and facilities related incidents related to Non-Critical Infrastructure Risk	2024/25	0	0	0	
Number of estates and facilities related incidents related to other	2024/25	0	1	0	
Overheating occurrences triggering a risk assessment (No.)	2024/25	0	2	0	
Flood occurrences triggering a risk assessment	2024/25	0	0	0	

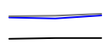
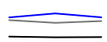
Accessibility	Data period	Provider value	Peer average	National value	National value method	Chart
Parking Spaces	2024/25	3,931	3,334	1,932	Provider median	
Disabled Parking Spaces	2024/25	161	153	93	Provider median	
% of Disabled Parking Spaces	2024/25	4.10%	4.77%	5.17%	Provider median	
• Disabled parking spaces (No.)	2024/25	161	153	93	Provider median	
• Car parking spaces available (No.)	2024/25	3,931	3,334	1,940	Provider median	
EPV Spaces	2024/25	0	12	14	Provider median	
% of EPV Spaces	2024/25	0.00%	0.37%	0.81%	Provider median	
• Electric vehicle charging points (No.)	2024/25	0	12	14	Provider median	
• Car parking spaces available (No.)	2024/25	3,931	3,334	1,940	Provider median	

Energy

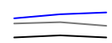
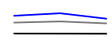
This section provides an overview of energy cost, consumption and sustainability metrics

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Overview	Data period	Provider value	Peer average	National value	National value method	Chart
Does the trust have an energy manager (Y/N)	2024/25	No	Yes	Yes	Provider median	
Energy costs per m² (£/m²)	2024/25	£51.76/m2	£50.56/m2	£45.65/m2	Provider median	
• Total Energy costs (£)	2024/25	£8.48m	£7.82m	£4.13m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Energy consumption per m² (kWh per m²)	2024/25	521.10	456.66	391.90	Provider median	
• Total energy consumed (kWh)	2024/25	85.42m	76.22m	36.69m	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Energy cost per patient (£/patient)	2024/25	£7.54	£6.29	N/A	Provider median	∅ No chart available
Energy consumption per patient (kWh/patient)	2024/25	75.91	56.39	N/A	Provider median	∅ No chart available

Energy costs	Data period	Provider value	Peer average	National value	National value method	Chart
Electricity - other costs (£/kWh)	2024/25	£0.304	£0.296	£0.268	Provider median	

Energy costs	Data period	Provider value	Peer average	National value	National value method	Chart
• Electricity - Other costs (£)	2024/25	£2.99m	£1.29m	£1.70m	Provider median	
• Electricity - Other consumed (kWh)	2024/25	9.83m	2.93m	6.57m	Provider median	
Electricity - green energy tariff cost (£/kWh)			∅ No data available			
• Electricity - green energy tariff cost (£)			∅ No data available			
• Electricity - green energy tariff consumed (kWh)			∅ No data available			
Electricity - trust owned solar cost (£/kWh)			∅ No data available			
• Electricity - trust owned solar costs (£)			∅ No data available			
• Electricity - trust owned solar consumed (kWh)			∅ No data available			
Electricity - third party owned solar costs (£/kWh)			∅ No data available			
• Electricity - third party owned solar costs (£)			∅ No data available			
• Electricity - third party owned solar consumed (kWh)			∅ No data available			
Electricity - other renewables costs (£/kWh)			∅ No data available			
• Electricity - other renewables costs (£)			∅ No data available			
• Electricity - other renewables consumed (kWh)			∅ No data available			
Gas cost (£/kWh)	2024/25	£0.071	£0.061	£0.059	Provider median	
• Gas cost (£)	2024/25	£4.45m	£2.80m	£1.37m	Provider median	
• Gas consumed (kWh)	2024/25	62.90m	51.30m	25.88m	Provider median	
Non-fossil fuel cost (£/kWh)	2022/23	£0.053	£0.047	£0.079	Provider median	
• Non-fossil fuel cost (£)	2022/23	£185.43k	£143.86k	£71,016	Provider median	

Energy costs	Data period	Provider value	Peer average	National value	National value method	Chart
• Non-fossil fuel consumed (kWh)	2022/23	3.49m	3.99m	791.27k	Provider median	
Electricity purchased from off-site CHP (£/kWh)		∅ No data available				
• Electricity purchased from off-site CHP cost (£)		∅ No data available				
• Electricity purchased from off-site CHP consumed (kWh)		∅ No data available				
Thermal Energy purchased from off-site CHP (£/kWh)		∅ No data available				
• Thermal Energy purchased from off-site CHP cost (£)		∅ No data available				
• Thermal Energy purchased from off-site CHP consumed (kWh)		∅ No data available				

Sustainability	Data period	Provider value	Peer average	National value	National value method	Chart
LED lighting coverage	2024/25	55.5%	61.4%	64.2%	Provider median	
• LED lighting coverage (m2)	2024/25	94,902m2	118.09km2	65,059m2	Provider median	
• Gross internal floor area (m2)	2024/25	171.04k	182.33k	102.55k	Provider median	
Green energy tariff electricity as a % of total electricity consumed	2024/25	0.0%	99.6%	89.4%	Provider median	
• Electricity - green energy tariff consumed (kWh)	2024/25	0	16.07m	2.84m	Provider median	
• Total electricity consumed (kWh)	2024/25	9.83m	18.95m	8.31m	Provider median	
Renewable electricity consumed as a % of total electricity consumed	2024/25	0.0%	0.2%	0.0%	Provider median	
• Renewable electricity consumed (kWh)	2024/25	0	36,400	0	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Sustainability	Data period	Provider value	Peer average	National value	National value method	Chart
• Total electricity consumed (kWh)	2024/25	9.83m	18.95m	8.21m	Provider median	
Number of energy efficient schemes	2024/25	1	1	1	Provider median	
Energy efficient schemes costs (£)	2024/25	£470.27k	£406.50k	£0	Provider median	
Investment per tonne of carbon saved (£/tonne)			∅ No data available			
• Energy efficient schemes costs (£)			∅ No data available			
• Carbon savings from investment in energy efficient schemes (tonnes CO2e)			∅ No data available			
Number of heat pumps	2024/25	1	1	2	Provider median	
Number of electric charging points	2024/25	0	12	14	Provider median	
Number of electric charging points as a % of total car parking spaces	2024/25	0.00%	0.37%	0.81%	Provider median	
• Electric vehicle charging points (No.)	2024/25	0	12	14	Provider median	
• Total car parking spaces available (No.)	2024/25	3,931	3,334	1,940	Provider median	

Waste

This section provides an overview of waste cost and consumption metrics

Data period: latest available at the time of generating this report

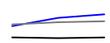
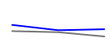
Peer group: 'My Peers - Estates & Facilities'

Overview	Data period	Provider value	Peer average	National value	National value method	Chart
Does the organisation have a waste manager?	2024/25	Yes	Yes	Yes	Provider median	
Does the organisation have a waste reuse scheme?	2024/25	No	Yes	No	Provider median	
Total waste cost (£/tonne)	2024/25	£642.61	£465.89	£465.21	Provider median	
• Total Waste cost (£)	2024/25	£1.80m	£1.28m	£622.45k	Provider median	
• Total Waste volume (Tonnes)	2024/25	2,802.03	2,627.32	1,365.10	Provider median	
Total clinical waste cost per patient (£/patient)	2024/25	£0.63	£0.48	£0.58	Provider median	
• Total clinical waste cost (£)	2024/25	£704.38k	£665.83k	£366.38k	Provider median	
• Total number of patients (No.)	2024/25	1.13m	1.26m	747.11k	Provider median	
Total domestic waste cost per patient (£/patient)	2024/25	£0.18	£0.22	£0.24	Provider median	
• Total domestic waste cost (£)	2024/25	£201.70k	£264.86k	£182.16k	Provider median	
• Total number of patients (No.)	2024/25	1.13m	1.26m	747.11k	Provider median	
Total waste volume per patient (Tonnes/patient)	2024/25	0.0025	0.0021	N/A	Provider median	∅ No chart available

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Overview	Data period	Provider value	Peer average	National value	National value method	Chart
Incineration (clinical waste) volume as a % of clinical waste	2024/25	22.0%	20.5%	14.7%	Provider median	
• Incineration (clinical waste) volume (Tonnes)	2024/25	298	237	83	Provider median	
• Total clinical waste volume (Tonnes)	2024/25	1,354.51	1,182.71	557.96	Provider median	
Alternative Treatment (clinical waste) volume as a % of clinical waste	2024/25	32.8%	24.9%	26.8%	Provider median	
• Alternative Treatment (clinical waste) volume (Tonnes)	2024/25	444	331	120	Provider median	
• Total clinical waste volume (Tonnes)	2024/25	1,354.51	1,182.71	557.96	Provider median	
Offensive waste volume as a % of clinical waste	2024/25	45.2%	42.9%	51.4%	Provider median	
• Offensive waste volume (Tonnes)	2024/25	612	577	183	Provider median	
• Total clinical waste volume (Tonnes)	2024/25	1,354.51	1,182.71	557.96	Provider median	

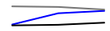
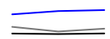
Waste costs - Clinical	Data period	Provider value	Peer average	National value	National value method	Chart
Incineration (clinical waste) cost (£/tonne)	2024/25	£837	£785	£1,038	Provider median	
• Incineration (clinical waste) cost (£)	2024/25	£249.87k	£198.83k	£79,012	Provider median	
• Incineration (clinical waste) volume (Tonnes)	2024/25	298.45	236.99	84.64	Provider median	
Alternative treatment (clinical waste) cost (£/tonne)	2024/25	£486	£566	£599	Provider median	
• Alternative treatment (clinical waste) cost (£)	2024/25	£215.79k	£169.67k	£87,299	Provider median	
• Alternative treatment (clinical waste) volume (Tonnes)	2024/25	443.77	337.09	145.25	Provider median	

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

Model Health System

Waste costs - Clinical	Data period	Provider value	Peer average	National value	National value method	Chart
Offensive waste cost (£/tonne)	2024/25	£390	£340	£392	Provider median	
• Offensive waste cost (£)	2024/25	£238.71k	£172.96k	£74,587	Provider median	
• Offensive waste volume (Tonnes)	2024/25	612.29	653.90	221.40	Provider median	
Clinical waste processed on site cost (£/tonne)		∅ No data available				
• Clinical waste processed on site cost (£)		∅ No data available				
• Clinical waste processed on site volume (Tonnes)		∅ No data available				
Clinical waste processed at municipal waste plants cost (£/tonne)		∅ No data available				
• Clinical waste processed at municipal waste plants cost (£)		∅ No data available				
• Clinical waste processed at municipal waste plants volume (Tonnes)		∅ No data available				

Waste costs - Domestic	Data period	Provider value	Peer average	National value	National value method	Chart
Domestic waste (landfill) cost (£/tonne)	2020/21	£152	£257	£223	Provider median	
• Domestic waste (landfill) cost (£)		∅ No data available				
• Domestic waste (landfill) volume (Tonnes)		∅ No data available				
Domestic waste (recycling) cost (£/tonne)	2024/25	£184	£171	£213	Provider median	
• Domestic waste (recycling) cost (£)	2024/25	£54,630	£41,742	£29,862	Provider median	
• Domestic waste (recycling) volume (Tonnes)	2024/25	296.35	304.61	133.13	Provider median	
Domestic waste (incineration) cost (£/tonne)	2024/25	£156	£224	£205	Provider median	

Waste costs - Domestic	Data period	Provider value	Peer average	National value	National value method	Chart
• Domestic waste (incineration) cost	2024/25	£126.11k	£164.65k	£96,754	Provider median	
• Domestic aste (incineration) volume	2024/25	810.85	843.00	520.00	Provider median	
Domestic waste (food) cost (£/tonne)	2024/25	£35	£164	£164	Provider median	
• Domestic waste (food) cost (£)	2024/25	£9,528	£8,941	£6,979	Provider median	
• Domestic waste (food) volume (Tonnes)	2024/25	275.24	92.11	45.08	Provider median	
Domestic waste processed on site (£/tonne)	∅ No data available					
Confidential waste cost (£/tonne)	2024/25	£193	£128	£201	Provider median	
• Confidential waste cost (£)	2024/25	£11,432	£18,121	£14,838	Provider median	∅ No chart available
• Confidential waste volume (Tonnes)	2024/25	59	138	82	Provider median	∅ No chart available
WEEE waste cost (£/tonne)	2024/25	£0	£511	£632	Provider median	
• WEEE waste cost (£)	2024/25	£0	£6,408	£4,528	Provider median	
• WEEE waste volume (Tonnes)	2024/25	5.72	8.00	7.28	Provider median	

Carbon emissions	Data period	Provider value	Peer median	Provider median	Chart
Total clinical waste carbon emissions (kgCO2e)	2024/25	432.36k	366.91k	150.84k	
Clinical waste - HTI carbon emissions (kgCO2e)	2024/25	268.99k	213.59k	75,186	
Clinical waste - AT carbon emissions (kgCO2e)	2024/25	159.44k	118.82k	43,007	

Carbon emissions	Data period	Provider value	Peer median	Provider median	Chart
Clinical waste - OW carbon emissions (kgCO2e)	2024/25	3,925	3,698	1,172	
Clinical waste processed on site emissions (kgCO2e)	2024/25	0	0	0	
Clinical waste processed at municipal waste plants emissions (kgCO2e)	2024/25	0	0	N/A	∅ No chart available
Total domestic waste carbon emissions (kgCO2e)	2024/25	9,960	9,595	6,103	
Domestic waste - Landfill carbon emissions (kgCO2e)	2024/25	0	0	0	
Domestic waste - Recycling carbon emissions (kgCO2e)	2024/25	1,900	1,953	851	
Domestic waste - Incineration carbon emissions (kgCO2e)	2024/25	5,198	5,404	3,029	
Domestic waste - Food carbon emissions (kgCO2e)	2024/25	2,445	818	332	
Domestic waste processed on site carbon emissions (kgCO2e)	2024/25	0	0	0	
Confidential waste carbon emissions (kgCO2e)	2024/25	381	885	517	
WEEE carbon emissions (kgCO2e)	2024/25	37	49	42	

Water

This section provides an overview of water cost and consumption metrics

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Water cost	Data period	Provider value	Peer average	National value	National value method	Chart
Water and sewage cost per total water volume (£/m³)	2024/25	£3.32	£3.36	£3.32	Provider median	
• Water & sewage cost (£)	2024/25	£1.22m	£872.84k	£392.12k	Provider median	
• Total water volume (m3)	2024/25	367.68k	268.27k	122.81k	Provider median	
Water cost per patient (£/patient)	2024/25	£1.09	£0.67	£0.71	Provider median	
• Total Water and sewage cost (£)	2024/25	£1.22m	£872.84k	£443.15k	Provider median	
• Total number of patients (No.)	2024/25	1.13m	1.26m	745.53k	Provider median	

Water consumption	Data period	Provider value	Peer average	National value	National value method	Chart
Water volume per occupied floor area (m³/m²)	2024/25	2.24	1.58	1.28	Provider median	
• Water volume (m3)	2024/25	367.68k	268.27k	122.81k	Provider median	
• Occupied Floor Area (m2)	2024/25	163.93km2	168.97km2	94,350m2	Provider median	
Water consumption per patient (m³/patient)	2024/25	0.33	0.21	0.22	Provider median	
• Total Water consumed (m3)	2024/25	367.68k	268.27k	140.54k	Provider median	

Water consumption	Data period	Provider value	Peer average	National value	National value method	Chart
• Total number of patients (No.)	2024/25	1.13m	1.26m	745.53k	Provider median	

Food

Food metrics collected through various collection methods

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Food	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of Inpatient meals served by Electronic Meal Ordering system	2024/25	0.00%	0.00%	79.70%	Provider median	
• Inpatient meals served by Electronic meal ordering system (No.)	2024/25	0	0	392.43k	Provider median	
• Inpatient main meals requested (No.)	2024/25	1.28m	978.30k	799.99k	Provider median	
Inpatient ingredient cost per meal	2024/25	£1.10	£1.84	£2.07	Provider median	
• Inpatient ingredient cost (£)	2024/25	£1.41m	£2.03m	£1.50m	Provider median	
• Inpatient main meals requested (No.)	2024/25	1.28m	978.30k	799.99k	Provider median	

Number of Meals	Data period	Provider value	Peer median	Provider median	Chart
Number of meals provided to A&E and Urgent Care patients	2024/25	80,428	31,879	26,550	
Number of Staff / visitor meals served	2024/25	923.16k	317.52k	209.84k	

Food collection	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of Food from UK sources	∅ No data available					
Percentage of Food from Higher Environmental sources	∅ No data available					

Food collection	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of plant-based meals for patients	2024/25	0.26%	N/A	2.68%	Provider median	
• Number of plant-based meals provided to patients	2024/25	3,376	N/A	16,000	Provider median	
• Total number of inpatient meals provided	2024/25	1.28m	N/A	919.83k	Provider median	
Percentage of plant-based meals for staff / visitors	2024/25	24.37%	N/A	3.98%	Provider median	
• Number of plant-based meals provided to staff / visitors	2024/25	225.00k	N/A	10,950	Provider median	
• Total number of staff / visitor meals provided	2024/25	923.16k	N/A	325.00k	Provider median	

E&F Opportunities

Understand areas where efficiency opportunities may exist when your trust is benchmarked against medians of the pre-set Estates peer group.

Data period: latest available at the time of generating this report

Peer group: 'My Peers - Estates & Facilities'

Potential Opportunities - Summary	Data period	Provider target	Minimum	Maximum	Chart
Total Estates and Facilities opportunities (£)	2024/25	£0.00	£0.00	£4.94m	
Management (Hard and Soft FM) costs (£)	2024/25	£605.29k	£396.90k	£1.24m	
Hard FM potential opportunities (£)	2024/25	£0	£0	£1.42m	
Soft FM potential opportunities (£)	2024/25	£6.55m	£2.39m	£11.44m	

Potential Opportunities - Hard Facilities Management	Data period	Provider target	Minimum	Maximum	Chart
Estates and property maintenance opportunities (£)	2024/25	£5.02m	£1.98m	£7.19m	
Grounds and gardens maintenance opportunities (£)	2024/25	£0	£0	£0	
Water & sewage opportunities (£)	2024/25	£338.31k	£240.61k	£516.26k	

Potential Opportunities - Energy	Data period	Provider target	Minimum	Maximum	Chart
Total energy (£) (based on m2) opportunities (£)	2024/25	£126.99k	£0	£1.16m	
Electricity - green energy tariff cost opportunities (£)	2020/21	£0	£0	£0	

Potential Opportunities - Energy	Data period	Provider target	Minimum	Maximum	Chart
Gas opportunities (£)	2024/25	£545.40k	£92,596	£1.19m	
Oil opportunities (£)	2024/25	£0	£0	£277.21k	
Non-fossil fuel costs - renewable opportunities (£)	2022/23	10,039.21	0.00	49,889.30	

Potential Opportunities - Waste	Data period	Provider target	Minimum	Maximum	Chart
Total waste cost opportunities (£)	2024/25	£482.66k	£93,698.20	£684.04k	
Incineration (clinical waste) opportunities (£)	2024/25	£12,723	£0	£80,734	
Alternative treatment (clinical waste) opportunities (£)	2024/25	£0	£0	£15,018	
Offensive waste opportunities (£)	2024/25	£27,084	£0	£62,660	
Domestic waste (landfill) opportunities (£)	2020/21	£0	£0	£0	
Domestic waste (recycling) opportunities (£)	2024/25	£2,630	£0	£17,812	
Domestic waste (food) opportunities (£)	2024/25	£0	£0	£0	
Domestic waste (incineration) opportunities (£)	2021/22	£0	£0	£1,895	
Domestic waste (excluding incineration) processed on site cost opportunities (£)	∅ No data available				
Confidential waste opportunities (£)	2024/25	£2,704	£0	£6,431	
WEEE waste opportunities (£)	2024/25	£0	£0	£0	

Potential Opportunities - Soft Facilities Management	Data period	Provider target	Minimum	Maximum	Chart

Potential Opportunities - Soft Facilities Management	Data period	Provider target	Minimum	Maximum	Chart
Cleaning services opportunities (£)	2024/25	£2.53m	£1.29m	£3.17m	
Inpatient food services opportunities (£)	2024/25	£0	£0	£0	
Laundry and linen service cost opportunities (£)	2024/25	£623.72k	£206.51k	£804.56k	
Laundry opportunities (£)	2023/24	£0	£0	£0	
Portering services (£)	2024/25	£0	£0	£0	

About the peer group referenced in this report

Peer group

Your trust is benchmarked against the peer group My Peers - Estates & Facilities

Your custom list of peer organisations for this area or specialty

Peer group members

Calderdale and Huddersfield NHS Foundation Trust	Mid and South Essex NHS Foundation Trust
East and North Hertfordshire Teaching NHS Trust	North Bristol NHS Trust
East Lancashire Hospitals NHS Trust	North West Anglia NHS Foundation Trust
East Suffolk and North Essex NHS Foundation Trust	Northumbria Healthcare NHS Foundation Trust
East Sussex Healthcare NHS Trust	Portsmouth Hospitals University NHS Trust
Frimley Health NHS Foundation Trust	Royal Berkshire NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust	Royal Cornwall Hospitals NHS Trust
Hampshire Hospitals NHS Foundation Trust	Royal Devon University Healthcare NHS Foundation Trust
Lewisham and Greenwich NHS Trust	Royal Wolverhampton NHS Trust
Maidstone and Tunbridge Wells NHS Trust	Sandwell and West Birmingham Hospitals NHS Trust

South Tyneside and Sunderland NHS Foundation Trust

Worcestershire Acute Hospitals NHS Trust

United Lincolnshire Hospitals NHS Trust
Estates & Facilities report

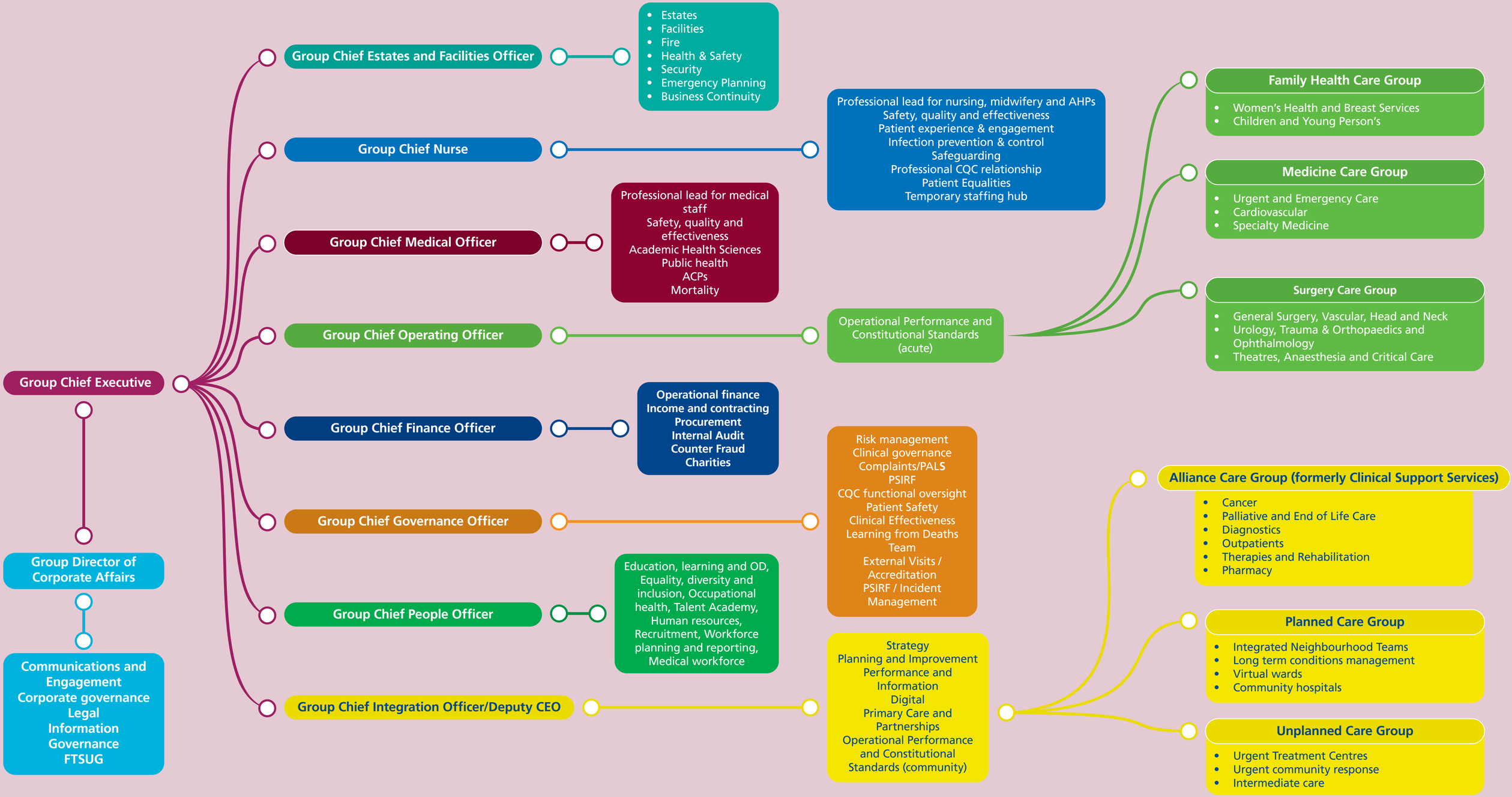
Model Health System

Colour meanings

The Model Hospital uses colour to indicate a trust's performance relative to a national median or mean or other benchmark. Different colours represent quartiles or Standard Deviation bands of the national data set or your trust's position on a red-amber-green scale.

For some metrics a relatively low value, putting the trust into Quartile 1 or -3SD would indicate a weak performance, but for other metrics a low value can indicate a strong performance. The colour coding helps you understand whether low values should be interpreted as weak or strong.

	Green	Either • Lowest quartile or positive outlier Standard Deviation band, where low represents best performance. • Highest quartile or positive outlier Standard Deviation band, where high represents best performance. • Performance better than benchmark, in a chart using a red-amber-green scale.
	Amber/green	Either • Mid-low quartile or better than expected Standard Deviation band, where low represents best performance. • Mid-high quartile or better than expected Standard Deviation band, where high represents best performance.
	Amber	• Performance approaching benchmark in a chart using a red-amber-green scale.
	Grey	• Performance within expected Standard Deviation band.
	Amber/red	Either • Mid-high quartile or worse than expected Standard Deviation, where low represents best performance. • Mid-low quartile or worse than expected Standard Deviation band, where high represents best performance.
	Red	Either • Highest quartile or negative outlier Standard Deviation band, where low represents best performance. • Lowest quartile or negative outlier Standard Deviation band, where high represents best productivity. • Performance below benchmark, in a chart using a red-amber-green scale.
	Blue	• We have not judged whether a high or low quartile, or positive or negative outlier Standard Deviation band is more desirable.


Group Chief Executive
Group Director of Corporate Affairs
Communications and Engagement
Corporate governance
Legal
Information Governance
FTSUG
Group Chief Estates and Facilities Officer
Estates
Facilities
Fire
Health & Safety
Security
Emergency Planning
Business Continuity
Group Chief Nurse
Professional lead for nursing, midwifery and AHPs
Safety, quality and effectiveness
Patient experience & engagement
Infection prevention & control
Safeguarding
Professional CQC relationship
Patient Equalities
Temporary staffing hub
Group Chief Medical Officer
Professional lead for medical staff
Safety, quality and effectiveness
Academic Health Sciences
Public health
ACPs
Mortality
Group Chief Operating Officer
Operational Performance and Constitutional Standards (acute)
Family Health Care Group
Women's Health and Breast Services
Children and Young Person's
Medicine Care Group
Urgent and Emergency Care
Cardiovascular
Specialty Medicine
Surgery Care Group
General Surgery, Vascular, Head and Neck
Urology, Trauma & Orthopaedics and Ophthalmology
Theatres, Anaesthesia and Critical Care
Group Chief Finance Officer
Operational finance
Income and contracting
Procurement
Internal Audit
Counter Fraud
Charities
Group Chief Governance Officer
Risk management
Clinical governance
Complaints/PALS
PSIRF
CQC functional oversight
Patient Safety
Clinical Effectiveness
Learning from Deaths
Team
External Visits / Accreditation
PSIRF / Incident Management
Group Chief People Officer
Education, learning and OD, Equality, diversity and inclusion, Occupational health, Talent Academy, Human resources, Recruitment, Workforce planning and reporting, Medical workforce
Group Chief Integration Officer/Deputy CEO
Strategy
Planning and Improvement
Performance and Information
Digital
Primary Care and Partnerships
Operational Performance and Constitutional Standards (community)
Alliance Care Group (formerly Clinical Support Services)
Cancer
Palliative and End of Life Care
Diagnostics
Outpatients
Therapies and Rehabilitation
Pharmacy
Planned Care Group
Integrated Neighbourhood Teams
Long term conditions management
Virtual wards
Community hospitals
Unplanned Care Group
Urgent Treatment Centres
Urgent community response
Intermediate care

NHS
Lincolnshire Community and Hospitals NHS Group

People Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*03 November 2026*
Agenda item number	*9.1*

People Committee Upward Report of the meeting held on 08 September 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 Group Board is asked to:* • **note** the discussions and assurance received by the People Committee. • **approve** the attached Freedom to Speak Up Annual Report • **approve** the attached Work Well Plan • **note** the attached August 2026 Communications and Engagement Dashboard

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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	*X*
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	*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 (i): Enhance our digital capability through innovation delivering the 10-year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	People Committee
Report from meeting held on:	08 September 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 08 September 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) 10 Point Plan for Improving Junior Doctors Working Lives
c) Guardian of Safe Working
d) Safer Staffing Medical
e) Safer Staffing Nursing

The Committee reviewed the Education Oversight Group upward report and noted the positive data highlighted in the report. At the end of July 2026 core learning compliance was at 92.57% for ULTH and 88.09% for LCHS against a national compliance target of 90%. The report noted that, for LCHS, the non-compliant position had improved in July from the 86.07% compliance position achieved in June 2026. The report reiterated that LCHS's continued non-compliance position was a temporary situation which would improve as the alignment with ULTH's core learning delivery model continued to embed.

CPD expenditure remained on track against the 2026/27 allocation, with significant preparation activity underway to support September 2026 university programme starts. The report also noted the need to be able to recognise the opportunities to strengthen financial oversight, improve understanding of how educational funding was utilised and ensure educational investment delivered maximum value and impact.

In relation to NHSE's proposed £1,000 per learner cap, the Committee was informed that the restriction represented a significant workforce risk, and the Group continued to engage with the NHSE to find a solution.

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

The Committee received a report on the progress of the implementation of the NHSE's 'Resident Doctor 10-Point Plan' which advised that overall progress remained positive, with most actions progressing as planned. The Committee noted that the remaining areas requiring improvement related largely to national payroll processes outside the Group's direct control.

The 'Resident Doctor 10-Point Plan' was launched in August 2025 and was viewed as a fundamental shift in how resident doctors and locally employed doctors were supported and employed. The actions being implemented under the Plan would strengthen employment practices and give parity with other NHS employees.

The Committee was **assured** by the report on the progress of the implementation of the NHSE's 'Resident Doctor 10-Point Plan'.

The Committee received the Guardian of Safe Working's report which highlighted that during the reporting period of April to June 2026, 86 exception reports were submitted by 27 resident doctors in training. The Committee noted that this represented 8% of the 330 resident doctors in training, and that 6 of those exception reports awaiting final resolution.

The report stated that 84% of the exception reports continued to be about additional hours worked due to unscheduled late finishes. This was indicative of workload pressures and service demands impacting doctors' ability to complete duties within scheduled hours. The Committee was informed that continued monitoring, alongside improvements in rota data quality and workforce planning, would be important to ensure safe working hours and positive training experiences for resident doctors in training.

The Guardian of Safe Working report provided **strong assurance** that exception reporting arrangements were operating effectively across the Group.

The Committee received the July 2026 Safer Staffing Medical report which highlighted the monitoring and management of medical and dental staffing establishments, supported by active recruitment programmes, stable turnover rates, and established workforce governance arrangements. The report highlighted that consultant vacancies had declined from 41 WTE to 37.75 WTE, reflecting recent recruitment activity, and noted that sickness absence and appraisal compliance remained broadly stable.

The report however, provided **limited assurance** due to continued concerns regarding care group-driven expenditure on temporary medical staffing, which remained above baseline levels despite ongoing improvement initiatives. The

Committee was informed that the focus of improvement actions was on improving workforce utilisation and reducing reliance on temporary staffing rather than on reducing workforce numbers.

The Committee received the Safer Staffing Nursing report, which provided **reasonable assurance** there was no evidence of widespread staffing related harm, although material workforce risks remain within specific services. The July 2026 report also highlighted the improved vacancy within Community Nursing, stable workforce and improving quality within Community Hospitals, continued High Assurance within UTCs and Maternity, reduced agency use within several services and completion of the 2026 Group Safe Staffing and Workforce Establishment Assurance Review.

The workforce establishment review found that the principal areas requiring continued oversight were ULTH healthcare support worker (HCSW) availability, sickness and increasing unregistered enhanced care demand, Community Nursing pressure damage, absence and mandatory training, mandatory training and competency assurance more broadly, and profession specific Allied Health Professions (AHP) recruitment pressures. These risks remain visible and were supported through SafeCare, Professional Judgement, local escalation, temporary staffing, workforce transformation and service specific improvement programmes.

Assurances in respect of Objectives 2b:

a) Workforce Strategy Group Upward Report and Committee Performance Dashboard
b) Workforce Hub
c) Workforce Plan
d) National Staff Survey Feedback
e) Freedom to Speak Up Annual Report

The Committee received the Workforce Strategy Group Upward Report and noted that the data indicated that overall, the vacancy and turnover rates for both ULTH and LCHS improved in August 2026, The Committee noted that these improvements reflected the sustained focus on recruitment, retention and workforce management across the Group

For ULTH and LCHS, the sickness absence rate increased in August 2026. The Committee noted that although the sickness rates increased, it remained within the level of tolerance for the Group's workforce plan. In August 2026, the number of exclusions increased in ULTH.

The Committee noted that the main risks remained around workforce planning, sickness absence, exclusions and employee relations case management. The Committee was **assured** by the report and the mitigating actions being implemented to manage both ongoing and emerging risks.

The Committee received the Workforce Hub Upward Report with a focus on workforce redeployment activity, management of staff affected by

organisational change, and oversight of employee exclusions across the Group. The report provided **reasonable assurance** to the Committee and reflected that effective governance arrangements were in place through the Workforce Hub to oversee redeployment, support organisational change programmes, minimise redundancy risk, and monitor employee exclusions. The report stated that continued scrutiny would be maintained in relation to Patient Services Hub redeployment outcomes and the increasing number of information governance-related exclusion cases.

The report informed the Committee there were 59 members of staff on the risk register with 58 actively engaged in recruitment processes. This demonstrated a well-functioning redeployment model with strong progression into alternative roles. The Committee noted that in terms of the at-risk process, the redundancy risk remained limited, with only three individuals still at risk of redundancy outside of the Patient Services Hub programme.

The Workforce Hub Upward Report provided an employee exclusions update which described to the Committee the effective and well-managed processes for handling employee relations cases. The Committee noted that there was a clear focus on minimising the use and duration of exclusions while maintaining appropriate safeguards, where appropriate, following formal risk assessment.

The report highlighted the sustained improvements with 9 weeks currently being the average length of exclusions, which was evidence of the impact of strengthened oversight and case management processes. There had been a month-on-month increase from 31 cases in July 2026 to 37 cases in August 2026, and this was attributable to a range of matters considered during the reporting period. Assurance was provided that appropriate support arrangements were in place for all affected staff.

The Committee received the 2026/27 Group Workforce Plan and noted that the plan was to achieve a balanced position, enabling a strategic shift of resource into community services while delivering an overall net reduction of 285 FTE by March 2027 aligned to system and financial objectives. The Committee was informed that the Group had delivered 73.38 FTE of the required 285 FTE reduction target.

The Committee was **substantially assured** by the report on the 2026/27 Workforce Plan.

The Committee received a Quarterly Pulse Survey Feedback report which included the Quarter 2 National Quarterly Pulse Survey results and the proposed approach to the 2026 National Staff Survey.

The Quarter 2 survey results indicated that the response rates remained stable, with a total of 2,763 staff members responding to the survey questionnaire. The report advised that the feedback across ULTH and LCHS remained consistent with previous surveys and cultural reviews, highlighting

concerns regarding leadership visibility, organisational trust, communication, workload pressures, wellbeing and involvement in decision-making. Actions continued through the Group Culture Action Plan, focusing on organisational trust, advocacy, wellbeing and career development, with ongoing work to strengthen leadership accountability and demonstrate how feedback was informing change.

The Committee also received a report which outlined the engagement approach for the 2026 National Staff Survey across the Group. The Committee noted that the aim of the outlined approach was to maximise participation, strengthen leadership accountability for staff engagement, and ensure staff feedback was translated into meaningful organisational improvement.

The Committee was **substantially assured** by the National Staff Survey Feedback report.

Assurances in respect of Objectives 2c:

a) Employee Relations Activity including Employee Exclusions
b) Culture and Leadership Group Upward Report

The Committee received a report which outlined the continued strengthening of Employee Relations (ER) performance within the Group as at the end of August 2026. The Committee noted that since the Introduction of the case review process in May 2025, the Group has demonstrated sustained progress, increased consistency, and a more proactive approach to resolving complex workforce matters.

The report informed the Group that a total of 192 cases had been closed between January 2026 and August 2026, reflecting a significant uplift in throughput and a more disciplined approach to case management. The Committee noted that disciplinary matters represented the largest category of closures (79 cases), followed by grievance cases (49). The average exclusion length had reduced to 9 weeks at ULTH and 5 weeks at LCHS, providing strong assurance that improved governance, decision-making, and escalation processes had been embedded.

The report stated that where delays in resolving cases occurred, the causes were well understood, transparently recorded, and largely attributable to factors outside the People Directorate's direct control. The factors which caused delays included availability constraints for investigating officers and external agency involvement. The Committee noted that focused actions had been undertaken to mitigate these factors, and the implementation of the new People Directorate structure would further strengthen resilience, standardisation, and ongoing case governance.

The Committee was **reasonably assured** by the Employee Relations report.

The Committee received an update on the culture and leadership work being undertaken in the Group and was **reasonably assured** by the progress being made against the relevant initiatives and actions. The report highlighted appraisal compliance as the principal area requiring further improvement actions. The Committee noted that this was because while Community Services had achieved above 91% compliance, the compliance rate for Acute Services remained at 61% with over 3,000 appraisals outstanding.

The report updated the Committee on the improvement actions being implemented, including the institution of recovery trajectories for the areas with the high non-compliance rates and the work to further embed the appraisal window approach which was adopted in 2025/26.

The Committee was **assured** by the Culture and Leadership Group Upward Report

The Committee received the revised (**attached**) Freedom to Speak Up Annual Report which reflected themes and activity previously reported through quarterly updates. The Committee reviewed and noted that the report had been revised following Committee feedback.

The Committee **approved** the Freedom to Speak Up Annual Report for submission to the Group Board.

Assurances in respect of Objectives 2d:

a) Communications and Engagement Dashboard
b) Recognition and Staff Achievements Report for August 2026

The Committee reviewed the August 2026 Communications and Engagement Dashboard (**attached**) and noted the various headlines. The headlines including the top 7 things raised in the month on staff closed Facebook pages, top news items, key internal messages for the month, and the forthcoming public engagement activities.

The Committee reviewed the revised Recognition and Staff Achievements Report August 2026 and noted that it provided a comprehensive overview of staff achievements and recognition activity across the Group.

Assurances in respect of other areas:

a) Presentation – The Work Well Plan 2026-2030
b) Board Assurance Framework
c) Risk Report including Risk Register
d) Legal, Regulatory and Topical Update

The Committee received and noted the positions in respect of the Board Assurance Framework, Risk Report and the Legal, Regulatory and Topical Update.

The Committee received a presentation on the Work Well Plan, which was described as the key enabler of the Group's Strategy. The goal of the Plan as to ensure that the Group had the people, capability and culture to support the delivery of its Strategy and the transition to a single organisation.

The Committee was **substantially assured** that the Plan was fully aligned to the Group's strategic aims which were – 'Better Care' for patients; 'Better Opportunities for people; and 'Better Health' for the population of Lincolnshire. The Plan also supported the delivery of the NHS 10 Year Health Plan and its 3 key priorities which were – shift 1: from hospital care to community care; shift 2: from treating sicknesses to the prevention of sicknesses; shift 3: from analogue systems to digital systems.

The Committee reviewed and **endorsed** the (**attached**) Work Well Plan for approval by the Group Board.

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 None

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the People Committee.
- approve the Freedom to Speak Up Annual Report (attached)
- approve the Work Well Plan (attached)
- note the attached August 2026 Communications and Engagement Dashboard

Jim Connolly, Non-Executive Director (Acting Chair)

08 September 2026



LCHG Freedom to Speak Up Annual Report 2025-2026

Executive Summary....3
National Update....3
Local Update....3
2025 National Staff Survey (NSS) results....4
Reported Data 2025/2026....6
Historical Data....6
Monthly Breakdown of Cases....8
Cases by Staff Role....8
Contacts by Theme....9
Care Group and Directorate Breakdown....10
Summary....15

Executive Summary

This report provides information on the speaking up activity across the Lincolnshire Community and Hospitals Group between 1 April 2025 and 31 March 2026. It provides a summary of:

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

National Update

Following on from the announcement of the National Guardians office function transferring to NHS E further communications have occurred with the regional network regarding transitional planning, this has taken the form of an open feedback session alongside a very comprehensive questionnaire for guardians. Both group guardians took advantage of this opportunity and feel were able to state their views on how the service can maintain safe speak up processes. A further communication advised that the NGO remained until end of June 2026 after which the transition was finalised.

Local Update

This report is compiled from joint group data, for the year 25/26 and has been a productive exercise in enabling comparison and embedding of a more comprehensive approach to collecting speak up data between acute and community settings.

The guardians are working closely to align materials and processes, and this has ensured that the communications via the Group reflect the positive alignment.

The FTSUGs are benefitting from joint sessions with senior leaders which has provided learning and growth opportunities for both guardians.

Capacity issues have been addressed through working together and the interface between face-to-face activity, promotional activity and corporate responsibilities has been acknowledged. In 2026 there is a plan to further review the speak up capacity required across Group and the allocation of resource.

Themes and statistics are triangulated with other data sources in the organisation as well as with members from the regional FTSU network and used to assess how the service can be improved, and what learning has taken place.

The Lincolnshire system FTSUGs meet quarterly to provide peer support and supervision as well as joining regional networking sessions with other Guardians.

Completion of the Board Reflection and Planning Tool was planned for June 2026. The self assessment will be used to identify strengths, gaps and practical actions to improve speaking up culture. Aligning board members with national expectations on speaking up ensures accountability and promotes a well led organisation.

2025 National Staff Survey (NSS) results

LCHS

There has been a continued decline in the results for the speak up questions at LCHS, there has been a larger decline in q25f. The decline in confidence that the organisation would address any concerns raised could also triangulate with the data showing that the Trust has seen a decline in the number of contacts to the FTSU Guardian.

A statement from the National Guardians Office about the decline in the results of the national staff survey for speaking up questions nationally is included at the end of this section.

	LCHS	Historical				
	Question		2021	2022	2023	2024	2025
q20a	Would feel secure raising concerns about unsafe clinical practice		82.7%	81.4%	79.4%	78.7%	76.5%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice		72.7%	68.7%	66.1%	65.4%	62.0%

q25e	Feel safe to speak up about anything that concerns me in this organisation		73.4%	74.5%	72.2%	69.4%	65.2%
q25f	Feel organisation would address any concerns I raised		63.1%	63.6%	59.7%	59.1%	51.7%

ULTH

There has also been a decline seen in year in the results for the speak up questions at ULTH which is disappointing following four years of steady improvement in scores in this area. The furthest deterioration has been in respect of feeling safe to speak up and confidence that the organisation would address any concerns raised. ULTH has not seen a decline in contacts with the FTSU Guardian in year.

	ULTH	Historical				
	Question		2021	2022	2023	2024	2025
q20a	Would feel secure raising concerns about unsafe clinical practice		66.8%	65.2%	66.0%	66.5%	65.5%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice		44.1%	45.5%	47.6%	48.2%	46.9%
q25e	Feel safe to speak up about anything that concerns me in this organisation		47.6%	53.2%	53.6%	55.5%	51.9%
q25f	Feel organisation would address any concerns I raised		32.0%	36.9%	39.4%	42.0%	37.6%

Statement from the NGO 18th March 2026 in response to the NSS results.

"The 2025 NHS Staff Survey was published last week, and the results on speaking up are disappointing.
The raising concerns (or Freedom to Speak Up) sub-score has fallen to 6.37, which is the sharpest single-year decline the survey has recorded.

The survey found six in ten staff feel safe to speak up about anything that concerns them, while just under one in two (47.6%) believe their organisation would act if they did so.

Against that backdrop, it is notable that the number of cases being raised with Freedom to Speak Up guardians is rising. This highlights the importance of staff having access to multiple routes to speak up, with the guardian role providing a crucial, trusted option for doing so.

We hope that Freedom to Speak Up guardians working within NHS organisations will be able to review their organisation's staff survey results, and work with their leaders to support local reflection, identify areas for improvements to further strengthen safe and supportive speaking up cultures."

Reported Data 2025/2026

Reporting Period 2025/26	ULHT	LCHS
Number of issues raised	423	124
Number of issues raised anonymously	13 (3%)	1
Number of issues raised with an element of Patient Safety	53 (13%)	16 (13%)
Number of issues raised about systems and processes	64 (15%)	86 (70%)
Number of issues raised with an element of worker safety	90 (21%)	20 (16%)
Number of issues raised with elements of Bullying/Harassment	32 (8%)	10 (8%)
Number of issues raised with elements of Behaviour and Relationships	123 (29%)	47 (37%)
Did the reporter describe having suffered detriment from speaking up	1	3 (2%)
Number of issues raised through Champions (not included in figures raised through FTSUG)	25 (6%)	6 (4%)

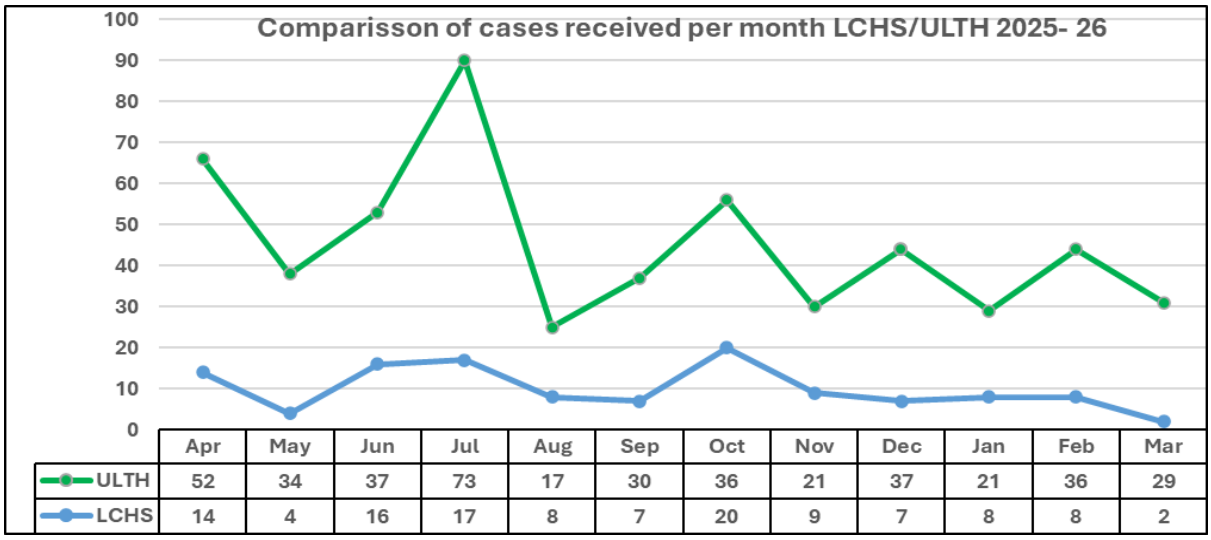
Historical Data

Reporting Period 2023/24	ULHT	LCHS
Number of issues raised	401	88

Number of issues raised anonymously	4	1
Number of issues raised with an element of Patient Safety	51	10
Number of issues raised about systems and processes	No data collected	No data collected
Number of issues raised with an element of worker safety	129	5
Number of issues raised with elements of Bullying/Harassment	84	19
Number of issues raised with elements of Behaviour and Relationships	79	64
Did the reporter describe having suffered detriment from speaking up	2	1
Number of issues raised through Champions (not included in figures raised through FTSUG)	55	No data collected

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

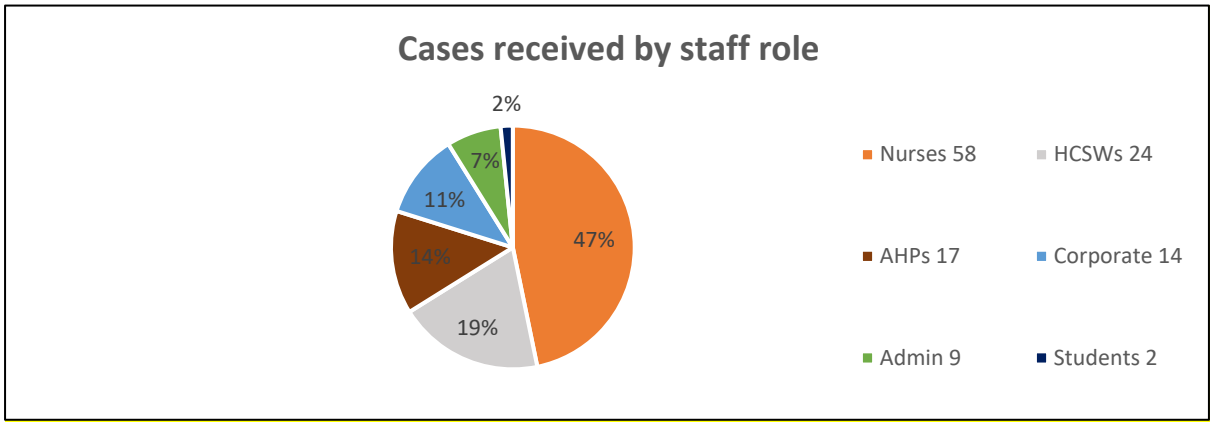
Monthly Breakdown of Cases



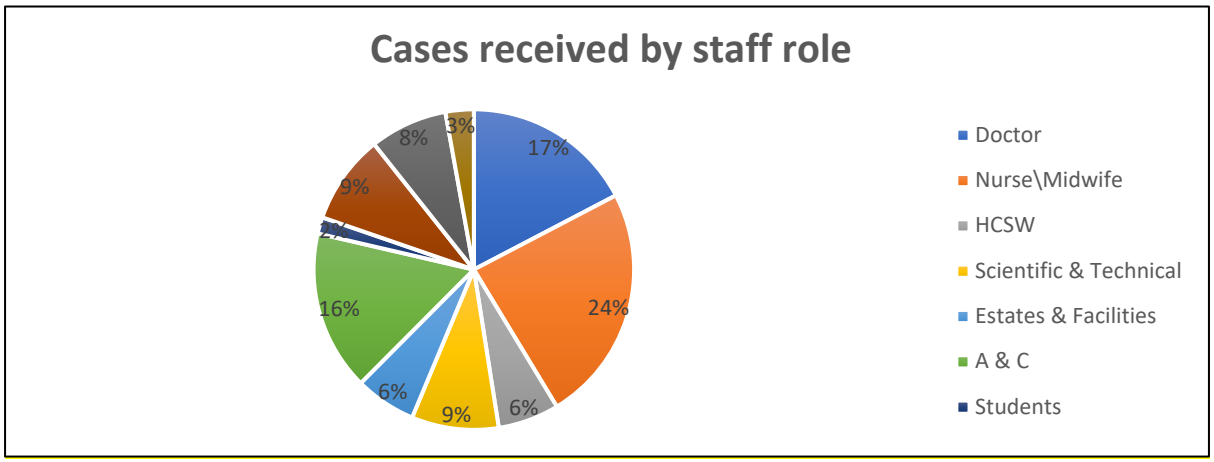
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ULTH	52	34	37	73	17	30	36	21	37	21	36	29
LCHS	14	4	16	17	8	7	20	9	7	8	8	2

Cases by Staff Role

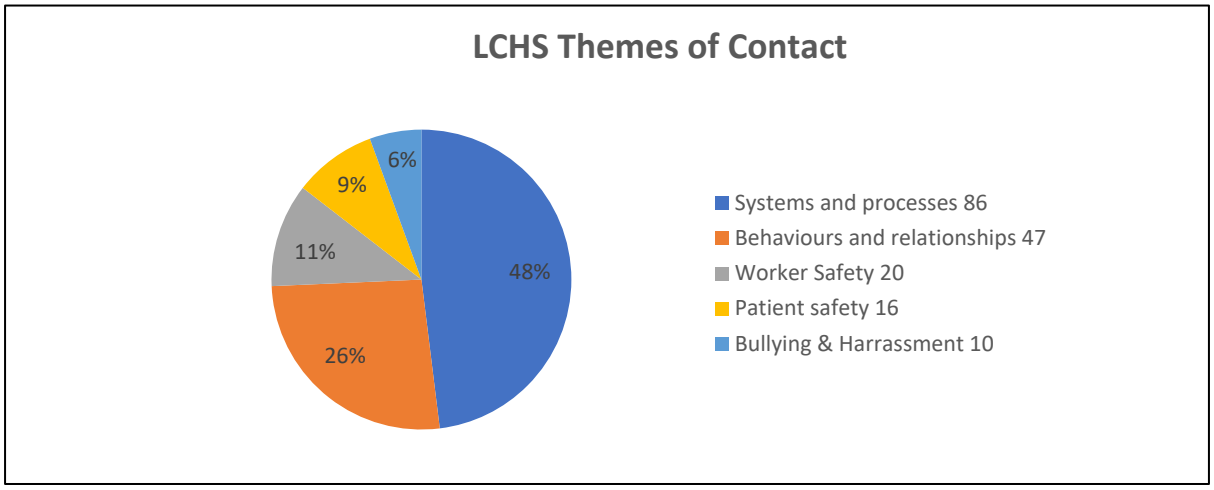
LCHS



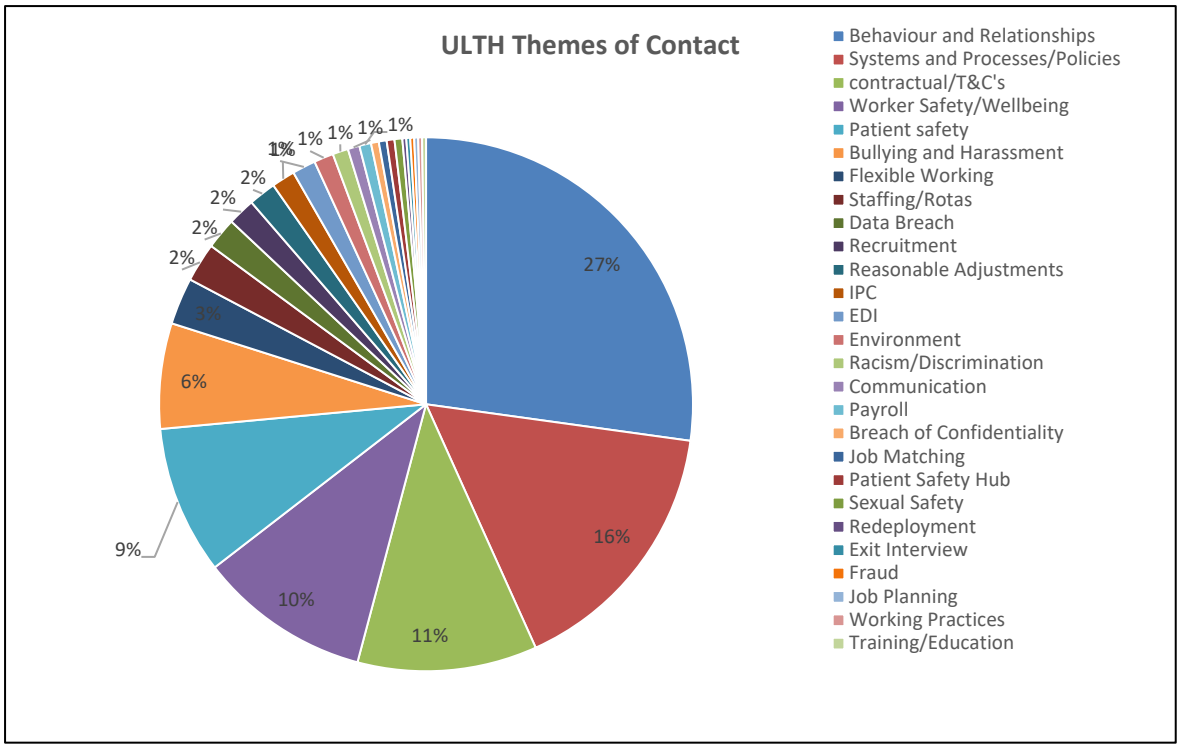
ULTH



Contacts by Theme

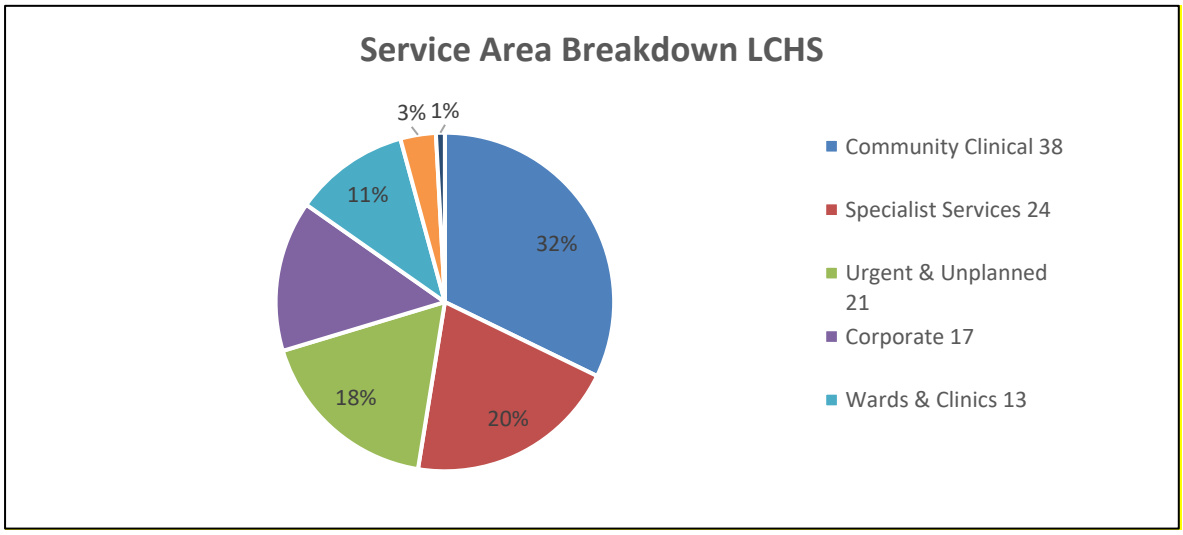


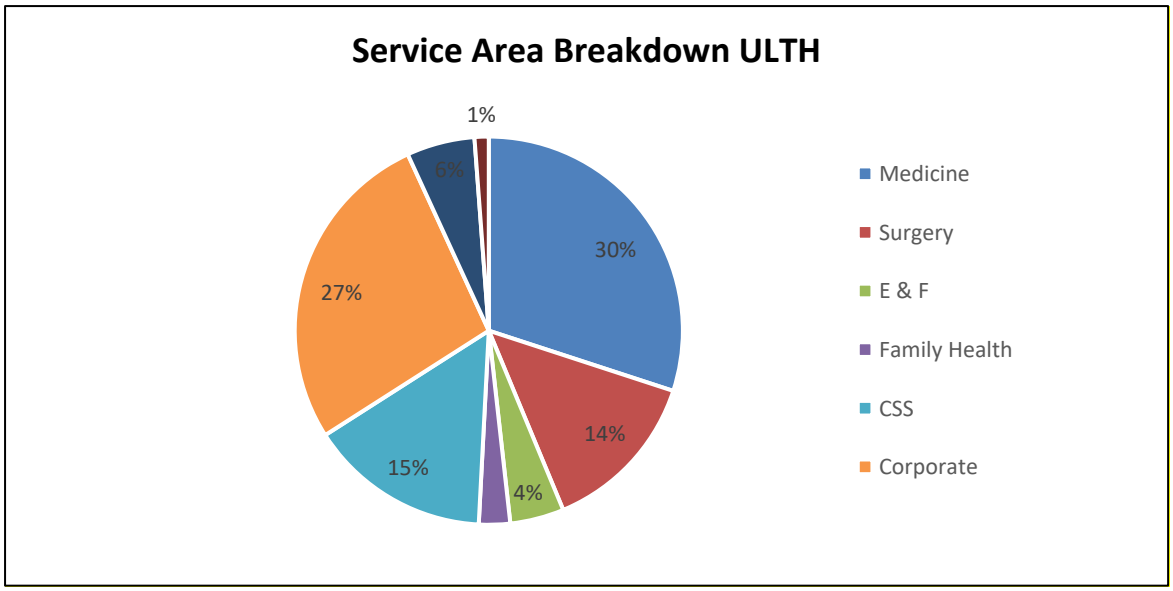
- 'Staff Experience' includes behaviours, communication issues and relationships.
- Systems and Processes - includes service change, questioning decisions, recruitment and selection, leave and interpretation of policies.
- Worker safety' includes health & safety at work and emotional wellbeing issues.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



- Behaviour and Relationships
- Systems, Processes and Policies
- Contractual/T&C's
- Worker Safety and Wellbeing

Care Group and Directorate Breakdown





Highlight Report LCHS	Action/Outcome/Narrative
System and Processes	71% of cases were relating to systems and processes, this includes service change, questioning decisions, recruitment and selection, leave, grievance support, interpretation of policies and staff subject to investigation/HR processes. This feature has increased over the last 2 years. The FTSUG mainly signposted these to other areas such as unions or encouraged open dialogue with leaders and HR staff. Many of these cases reflect changes to services in line with national requirements, although a significant amount relate to mileage payments. Contacts to the guardian may indicate a lack of trust from staff and/or fear. The themes and narrative of the speak ups have been communicated to leaders at all levels. Contacts pertaining patient safety remain low and the issues are predominantly relating to staffing levels, no contacts have been received regarding poor care either

	systemically or deliberately. Staff survey results reinforce this. Verbal feedback from staff indicates staff feel more able to openly report incidents of patient safety than they would behaviour issues. The aim would be that both are reported/discussed with equal freedom.
Patient Safety	Contacts pertaining patient safety remain low and the issues are predominantly relating to staffing levels, no contacts have been received regarding poor care either systemically or deliberately. Staff survey results reinforce this. Verbal feedback from staff indicates staff feel more able to openly report incidents of patient safety than they would behaviour issues. The aim would be that both are reported/discussed with equal freedom.
Detriment cases:	LCHS had 3 reported cases of felt detriment from speak up contacts, one of the contacts had re-reported and hence the case was re-opened. Both cases followed the Midlands Detriment protocol.

Highlight report ULTH	**Action/Outcome/Narrative**
Behaviours and Relationships	27% of cases raised with the FTSUG remains around Behaviour and Relationships. Staff have reported issues with colleagues and management and especially in the latter, feel unable to escalate in the division due to either feelings of not being listened to, favourtism, nepotism, bias or it's futile, so

	feel the only avenue they have is to contact the FTSUG, go on sick leave or leave the organisation. The 2025 NSS is showing a decline in staff feeling safe to speak up, locally and nationally. The Safe to Say campaign has been re-launched, supported by the FTSUG and Champions and Speak Up is on all staff compliance to encourage staff to feel psychologically safe. Future work will include managers and the listen up training, so they are equipped to actively listen and address concerns, also working in collaboration with the Organisational Development Team to support all staff to have an open and transparent culture and the Culture and Leadership Programme.
Systems/Processes/Policies	Recruitment – concerns have been raised regarding unfair recruitment, bias, nepotism, favouritism, discrimination – HR have carried out independent investigations, and none have been upheld. The FTSUG is being contacted from staff suffering with anxiety, stress awaiting outcomes of investigations which are taking longer than expected. FTSUG is working with wellbeing services to support staff and HR to gain ongoing communication and outcomes as soon as possible. FTSUG is also advising staff to work with their union and staff side representatives. Staff have also contacted the FTSUG regarding job matching, terms and conditions, job descriptions, annual leave, staff sickness management and other contractual issues, the majority of these

	cases are signposted to the relevant policies, processes, management structure, HR or union/staff side.
Contractual/T&C's	A number of staff contacted the FTSUG relating to their contracts, job planning and terms and conditions. The senior leadership team and HR were also informed and the concerns were addressed in a timely manner through the correct processes. Concerns around job planning, job matching, job descriptions, have also been escalated to appropriate management and HR.
Worker Safety/Wellbeing	Staff morale is being reported as low, which coincides with the staff survey results 2025 and the increase in referrals to the wellbeing services, internal and external. The staff survey results are showing a decline in staff feeling safe to speak up or feeling it is futile as issues are either not addressed or processes are lengthy, leading to anxiety, depression and feelings of not being valued. The organisation is currently going through change, with a new Board, working in Group, changes with the Patient Services Hub and other re-structures, which is adding to feelings of uncertainty. The Wellbeing Services are working in collaboration with the FTSUG and HR to support our staff through these changes.

Summary

This report summarises the group contacts to Speak up Guardians for 2025/26. The issues raised and lessons learned have been submitted quarterly to the People Committee and the PSIRF meetings. Additionally, FTSUGs are able to disseminate themes, findings and recommendations via operational delivery group, culture and leadership group and People Committee.

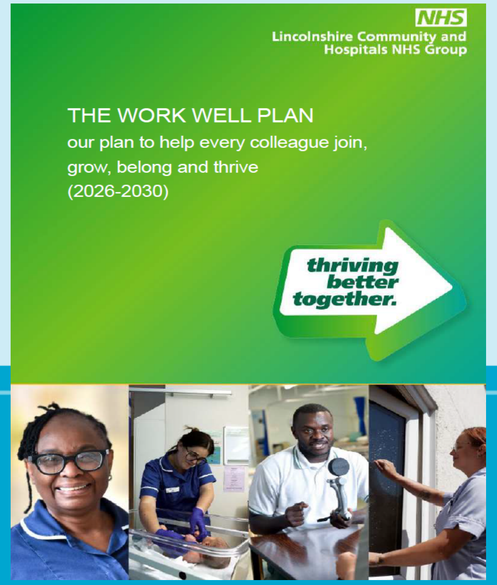
Opportunity to explore the themes are incorporated into the reporting process and FTSUGs are able to expand on the narrative around specific themes and outcomes.

2026/27 will see the formulation of a Group Speak Up Plan based on the output of the NSS Results and the Board Planning and Reflection Tool. This will include a review of the impact of the FTSU Champions and creation of a Group approach to Champion engagement and Role Description.

People Committee

Lincolnshire Community and Hospitals NHS Group

The Work Well Plan 2026-2030 (our plan to help every colleague join, grow, belong and thrive)



Caring and building a healthier future for all

The Work Well Plan - Enabler of the LCHG Strategy

- Key enabler of the LCHG Strategy – ensuring we have the people, capability and culture to deliver.
- Direct alignment to the 3 LCHG strategic aims:
- **Better Care (Patients)** – safe strong leadership and continuous improvement enable high-quality, efficient, patient-centred care.
- **Better Opportunities (People)** – clear career pathways, talent development and inclusive leadership unlock potential and drive innovation.
- **Better Health (Population)** – a flexible, community-focused workforce supports prevention, integration and reduced inequalities.



Supporting delivery of NHS long term priorities

- Aligned to national direction, particularly the NHS 10 Year Health Plan and key priorities:
- **Shift 1: hospital to community** – through new workforce models and strengthening supply pipelines into community settings.
- **Shift 2: sickness to prevention** – through population health capability and culture that prioritises early intervention and proactive care.
- **Shift 3: analogue to digital** – through a digitally confident workforce and modern, digital systems.

Impact for LCHG

Improving productivity, sustainability and workforce stability:

- Better recruitment and onboarding to reduce vacancies.
- Retention and wellbeing interventions to reduce turnover and sickness.
- Workforce planning and deployment to optimise staffing models.
- Stronger culture, leadership and engagement.

Combined, these actions support financial sustainability while maintaining care quality

Strengthening Partnership and System Working

LCHG Strategy emphasises collaboration across the Integrated Care System and with wider partners. The Work Well Plan reinforces this by:

- Aligning education and workforce development with system partners.
- Supporting joint workforce planning and shared pipelines.
- Promoting inclusive leadership and partnership behaviours.

Enabling a truly integrated workforce capable of delivering system-wide transformation.

Our People Directorate Portfolios

Resourcing

- Attraction and pipeline
- Resourcing and onboarding
- Values-based selection

Education and Talent

- Talent and career development
- Education strategy
- Skills and capability building
- Statutory and mandatory training

Workforce

- Workforce planning and modelling
- Workforce data and systems
- Governance, risk and assurance
- Productivity and cost improvement

Human Resources

- People policy and frameworks
- Employee relations advice
- Legal compliance
- Organisational change support

Culture and Wellbeing

- Occupational Health and wellbeing Services
- Organisational and leadership development
- Reward and recognition
- Equity, diversity and inclusion

Our 5 Pillars – to develop, empower and retain great people











JOIN WELL	GROW WELL	WORK WELL	BELONG WELL	STAY WELL
Attract, welcome and induct people effectively	**Develop people's skills, careers and leadership**	**Create the conditions for people to perform and deliver excellent patient care**	**Build an inclusive and compassionate culture where everyone thrives**	**Protect the physical, mental and emotional health and wellbeing of our people**
• Inclusive values-based recruitment • Streamlined pre-employment checks and digital onboarding • Strong employer brand and proactive workforce supply pipelines • Clear job roles, expectations and structured local induction • Early support buddying, orientation and day one ready preparation	• Equitable access to education, training and CPD • Career pathways for all staff groups • Compassionate and inclusive leadership development • Talent management and succession planning • Support for new roles and advanced practice	• Effective workforce planning, e-rostering and job planning • Safe staffing and manageable workloads • Modern, flexible working practices and digital enablement • Consistent high quality line management • Regular 1:1s and appraisals • Values-based reward and recognition	• Strong EDI focus, reducing WRES/WDES inequalities • Civility, respect and zero-tolerance for discrimination • Staff networks and allyship to strengthen inclusion • Psychological safety and a strong "speak up" culture • Values-led behaviour at every level • Better Together Programme • Sexual Safety Charter	• Comprehensive health and wellbeing support • Flexible working and good work-life balance • Safe working environments and violence reduction efforts • Early intervention occupational health and effective sickness support • Financial wellbeing resources • Burnout prevention and resilience initiatives • Menopause awareness and support

How our Pillars align with our Strategic Aim and Objectives (underpinned by the NHS People Promise)

PEOPLE

Better Opportunities

AIMS

Develop, empower and retain great people

OBJECTIVES

- 2a Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture
- 2b Create a culture that empowers our people to deliver change through continuous improvement and innovation
- 2c Nurture compassionate and diverse leadership
- 2d Recognise our people through thanks and celebration



join well

work well

belong well

stay well

+



grow well

thriving better together.

Our **People Promise**



LCHG 3-Year Cultural Roadmap (2026-2029)

Year 1 (2026-2027)
– Design and Build

Outcome:
Clear culture, values, behaviours and enabling infrastructure

- Culture, values and behaviours in place
- Leadership foundations developed
- Clear career pathways and talent management

Year 2 (2027-2028)
– Embed and Normalise

Outcome:
Managers lead culture confidently

- Culture in action
- Consistent leadership behaviours
- Manager-led people decisions
- Leadership maturity (people teams step back)

Year 3 (2028-2029)
– Maximise and Evolve

Outcome:
Culture fully lived, adaptive, and self-sustaining

- Culture drives performance as ‘how we do business’
- Continuous improvement and innovation mindset
- Mature talent and leadership pipeline

Overall Outcome: Clear culture → manager-led ownership → self-sustaining, evolving culture

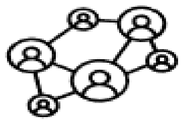
Leadership at the Heart of Culture

- Central to the roadmap is the role of leaders at every level.
- People directorate provides the framework, tools and support - leaders and managers bring culture to life through their **behaviours, decisions and interactions** with their teams.
- Every leader has their part to play in transforming our culture.
- Over time, the roadmap intentionally shifts ownership from the centre to the organisation - moving towards a model where culture is led and sustained locally, with the People directorate enabling rather than directing.

2026-2027 Annual Deliverables

- Focused set of priorities for each year, responding to both strategic ambitions and evolving needs of our organisation, workforce and external environment.
- 2026–2027 deliverables designed to:
  - Lay strong foundations in key areas such as recruitment, workforce planning, leadership development and culture.
  - Address immediate operational pressures, including workforce supply, retention and staff experience.
  - Build momentum for longer-term transformation, particularly in areas such as talent management, inclusion and wellbeing.
  - Establish the infrastructure, systems and behaviours needed to support sustained improvement over the life of the plan.
- Deliverables not fixed in isolation - part of a dynamic, multi-year programme of work. Priorities will be reviewed, refined and built upon each year to reflect progress, organisational priorities and emerging challenges.

The KPI Framework

People Plan Pillar	KPI Measure
 **Join Well**	Vacancy Rate Staff Turnover
 **Grow Well**	% Apprenticeship levy used each year NHS Staff Survey: 'We are always learning' Mandatory training and appraisal compliance National Education Training (NET) Survey
 **Work Well**	Appraisal compliance NHS Staff Survey: 'We are a team' NHS Staff Survey: 'We are recognised and rewarded'
 **Belong Well**	NHS Staff Survey: 'We are compassionate and inclusive' NHS Staff Survey: 'We each have a voice that counts' Just Culture compliance Sexual Safety incident reporting
 **Stay Well**	Sickness Absence Staff Turnover NHS Staff Survey: 'We are safe and healthy' NHS Staff Survey: 'We work flexibly'
 **All Areas**	NHS Staff Engagement Score (plus NQPS quarterly) NHS Staff Morale Score (plus NQPS quarterly) Organisation and Local Culture Plans WRES/WDES

Assurance and Governance

- Monthly reporting into People Directorate SLT relating to progress on delivery plan, highlighting any emerging risks.
- Quarterly reporting into People Committee Sub-Groups.
- Quarterly reporting upwards into People Committee based on progress against delivery plan.
- Links with KPIs and metrics within People Committee dashboard.
- Upward reporting to Board on progress through People Committee.

Summary

The Work Well Plan will help to:

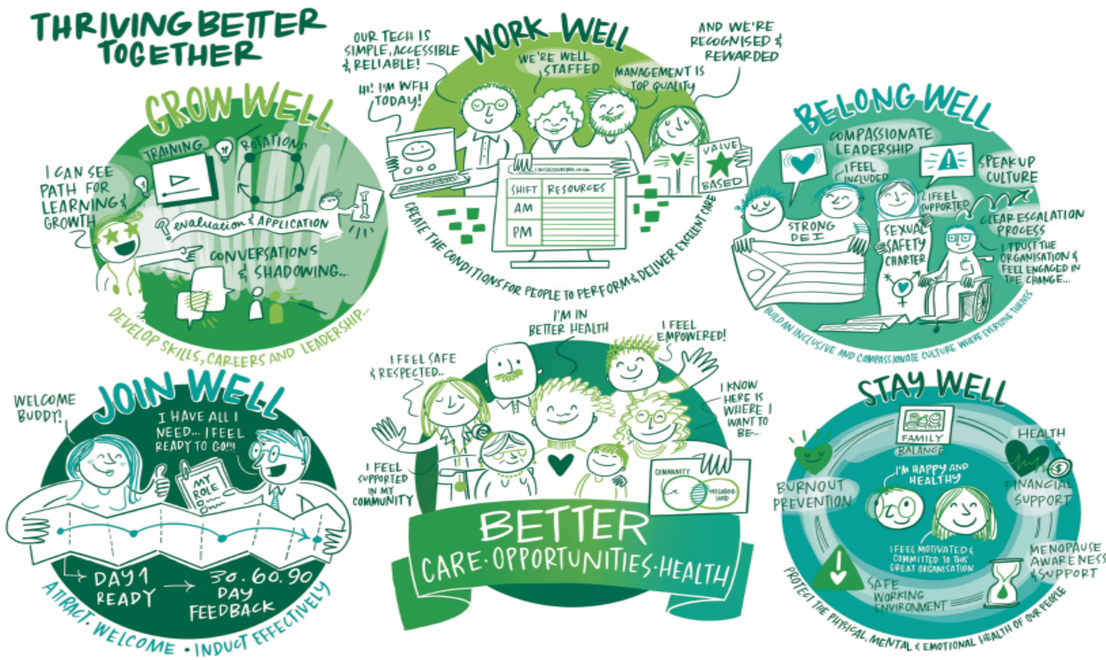
- Develop, Empower and Retain Great People

Through:

- Join Well • Grow Well • Work Well
- Belong Well • Stay Well

Supporting:

- Better Care • Better Opportunities
- Better Health



NHS
Lincolnshire Community and Hospitals NHS Group

People Committee Upward Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*03 November 2026*
Agenda item number	*9.1*

People Committee Upward Report of the meeting held on 16 October 2026

Accountable Director	*Claire Low, Group Chief People Officer*
Presented by	*Vicki Wells, Non-Executive Director*
Author(s)	*Kwame Mensa-Bonsu, Deputy Director of Corporate Affairs*
Recommendations / decision required	*The Group Board is asked to:* • ***note** the discussions and assurance received by the People Committee;* • ***note** the attached September 2026 Communications and Engagement Dashboard* • ***ratify** the attached revised People Committee Terms of Reference*

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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	*X*
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	*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 (i): Enhance our digital capability through innovation delivering the 10-year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	People Committee
Report from meeting held on:	16 October 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 16 October 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 Objectives 2a:

a) Education Oversight Group (EOG) Upward Report
b) Safer Staffing Medical
c) Medical Exclusions
d) Safer Staffing Nursing and Non-Medical
e) CQC Update

The Committee reviewed the Education Oversight Group upward report and noted the actions taken to strengthen education governance. The report noted that there had also been a review of the EOG's scope and the development of a consolidated view of education activity, funding and outcomes across the Group.

The Committee also noted that at the end of August 2026, statutory and mandatory training compliance was at 92.42% for ULTH and 89.58% for LCHS against a national compliance target of 90%. The report noted that the targeted support arrangements and direct intervention activity continued to have a positive impact on statutory and mandatory compliance performance.

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

The Committee received the September 2026 Safer Staffing Medical report which showed that though staffing establishment was adequate, there was **limited assurance** due to continued concerns regarding Care Group-driven

expenditure on temporary medical staffing. The report informed the Committee that the expenditure was above baseline levels despite ongoing improvement actions.

In September 2026, the medical and dental vacancy rate was at 7.73%, with the area with the highest number of consultant vacancies being Surgery. Medicine had the highest number of non-consultant vacancies in September 2026.

In September 2026, the Committee noted that the turnover rate for ULTH was at 5.52%, with the Medicine being the area with the highest turnover at 7.34%. The sickness rate was at 2.30% in September 2026, with Corporate being the area with the highest rate.

The report informed the Committee that the appraisal rate as at the end of September was at 92.3%.

The Committee reviewed a Medical Exclusions report which provided an anonymised review of six professional conduct, safeguarding and workforce concern cases managed across clinical services for the reporting period April 2025 – April 2026. The report provided **reasonable assurance** that the cases had been managed through robust, proportionate, and transparent processes, with patient safety and organisational accountability remaining the primary considerations throughout.

The Committee received the August 2026 Safer Staffing Nursing and Non-Medical report which provided **reasonable assurance** that while workforce pressures remain within a number of services, there continued to be no evidence of widespread staffing related harm.

The report stated that the greatest operational staffing pressure remained within ULTH with healthcare support worker availability continuing to be the principal substantive workforce risk. The workforce position in LCHS remained stable overall.

The Committee received a preliminary update on the actions being implemented following the publication in September 2026 of the CQC's report on their assessment visit to the Lincoln ED. The Committee was informed that the Group had changed both the layout in the Lincoln ED and some of the functionality required in the department to provide greater, safer oversight. The Group was also taking steps determine the safer staffing requirement for the Lincoln ED.

The Committee was updated on other work being employed to implement a domestic workforce model to provide refreshments to patients while they waited in the Lincoln ED. The Committee was informed that this was now an imperative as patients were waiting for long hours in the Lincoln ED. The update also highlighted work to review the medical and pharmacy rotas so that there was the appropriate medical and pharmacy cover for the ED as all times.

The Committee was **assured** by the preliminary update on the actions being implemented after the CQC assessment visit to the Lincoln ED in September 2025.

Assurances in respect of Objectives 2b:

a) Work Well Plan
b) Workforce Strategy Group Upward Report and Committee Performance Dashboard
c) Workforce Hub
d) Workforce Plan

The Committee received a report on the Work Well Plan which was launched in August 2026 as the Group's strategic framework for creating a workplace where staff felt feel welcomed, supported, valued, included and able to perform at their best. The Committee was informed that since the launch in August there had been strong progress across the five interconnected pillars of - Join Well, Grow Well, Work Well, Belong Well and Stay Well.

The report provided **substantial assurance** that the appropriate governance, delivery arrangements and supporting actions were in place to embed the Work Well Plan across the Group.

The Committee received the Workforce Strategy Group Upward Report and noted that the data indicated that overall, the ULTH vacancy and turnover rates improved in September 2026. For LCHS, the vacancy rate for Registered Nursing & Midwifery improved, but the vacancy rate for Medical and Dental increased slightly. The Committee noted that these improvements reflected the sustained focus on recruitment, retention and workforce management across the Group.

For ULTH, the number of employee exclusions, and bank and agency use increased in month. The sickness rate at ULTH also increased in September 2026 but was within the level of tolerance. The sickness absence rate at LCHS increased marginally in September 2026. In September 2026, the number of exclusions, and the average length of those exclusions, increased at LCHS.

The Committee noted that the main risks remained around workforce planning, sickness absence, exclusions and employee relations case management. The Committee was **assured** by the report and the mitigating actions being implemented to manage both ongoing and emerging risks.

The Committee received the Workforce Hub Upward Report with a focus on workforce redeployment activity, management of staff affected by organisational change, and oversight of employee exclusions across the Group. The report provided **reasonable assurance** to the Committee and reflected that the appropriate governance and support mechanisms were in place, whilst recognising ongoing risks associated with organisational change and redeployment activity.

The report noted that the Workforce Hub was being repurposed as a Work Well Delivery Group, to provide focused oversight of delivery of the Work Well Plan and progress against its action plan. The Committee noted that the change was intended to streamline governance arrangements, avoid duplication and establish a clear mechanism for monitoring and reporting progress against the Work Well Plan.

The Committee **endorsed** the repurposing of the Workforce Hub into the Work Well Delivery Group.

The Committee received the 2026/27 Group Workforce Plan and noted that the plan was to achieve a balanced position, enabling a strategic shift of resource into community services while delivering an overall net reduction of 285 FTE by March 2027 aligned to system and financial objectives.

The Committee was informed that the workforce position was 43.65 FTE outside of plan in September 2026. The report noted that a trajectory assessment to November 2026 indicated that the Group could remain approximately 69 FTE outside of plan if current trends continued. The Committee recognised temporary staffing utilisation as the principal workforce delivery risk to achievement of the Group Workforce Plan and will maintain enhanced oversight through the Temporary Staffing Oversight Group and Workforce Strategy Group.

The Committee noted the recovery programme being implemented, including strengthened temporary staffing controls, enhanced recruitment activity in high-vacancy areas, improved roster management, tighter vacancy governance, accelerated sickness absence improvement actions and targeted interventions through the Temporary Staffing Oversight Group.

The Workforce Plan report provided **substantial assurance** that there were effective governance arrangements, monitoring processes and recovery plans in place to ensure delivery of the planned target.

Overall, the Committee received **substantial assurance** that the appropriate governance arrangements are in place across the People portfolio. While workforce pressures continue in relation to temporary staffing, employee exclusions, appraisal compliance and delivery of workforce plan trajectories, the Committee was **assured** that mitigations and recovery actions are being actively managed. No issues requiring immediate Board intervention were identified.

Assurances in respect of Objectives 2c:

a) Equality Diversity and Inclusion Group Upward Report
b) Culture and Leadership Group Upward Report
c) Sexual Safety Charter
d) Single Sex Spaces
e) Employee Exclusions

The Committee received the Equality Diversity and Inclusion (EDI) Upward Report which provided **assurance** that good progress continued to be achieved against EDI improvement plan with most actions on track to be completed by January 2027. In relation to the EDI improvement plan, the report advised that only the Ethnicity Pay Gap and Disability Pay Gap actions were currently rated as amber pending completion of the required reporting and analysis.

The Committee noted that the implementation of the Lord Mann recommendations continued to be progressed with strengthened governance and dashboard development.

The Committee received an update on the culture and leadership work being undertaken in the Group and was **reasonably assured** by the progress being made against the relevant initiatives and actions. The Committee noted that acute appraisal compliance, although improving, remained at 65.72%. Improvement actions continue to be implemented to sustain the current improved trajectory.

The Committee was informed that, in support of the Left Shift Transformation Programme, six face-to-face Organisational Development World Café sessions had been undertaken to date. Further sessions had been planned, with a focus on five key themes - current left shift changes, leadership behaviours during change, speaking up, inclusion, and managing change fatigue.

The Committee received a Quarter 2 update on the implementation of the NHS Sexual Safety Charter in the Group. The report stated that the implementation continued to progress positively, with all but two of the ten charter requirements completed

The report noted that training compliance remained exceptionally strong, with Sexual Misconduct at Work eLearning completion rates being at 97.56% in LCHS and 96.59% in ULTH. Awareness of the Sexual Safety Charter has also continued to improve, reaching 68% in LCHS and 65% in ULTH.

The Committee was **substantially assured** that ongoing communication and engagement activities were successfully embedding the Charter across the Group.

The Committee received a report which informed it of the establishment of a Single-Sex Spaces Working Group. The report highlighted the Working

Group's programme of work and noted that the appropriate governance, risk management and stakeholder engagement arrangements were being developed. The Working Group had been established because of the UK Supreme Court ruling in April 2025 that, for the purposes of the Equality Act 2010, the terms "sex", "man" and "woman" refer to biological sex (sex at birth).

The Committee noted that the Working Group's work programme would support the Group's response to emerging national requirements relating to single-sex spaces because of the Supreme Court ruling. This was a significant organisational priority with implications across a wide range of services and functions, including workforce, estates and facilities, patient services, communications, equality impact assessments and risk management.

The Committee was **substantially assured** by the report on the Single-Sex Spaces Working Group.

The Employee Relations and Exclusions update described to the Committee the effective and well-managed processes for handling employee relations cases, noting that there was a clear focus on minimising the use and duration of exclusions while maintaining appropriate safeguards were appropriate following formal risk assessment.

The report noted that there had been a month-on-month increase from 37 cases in September 2026 to 47 cases in October 2026. The Committee was informed that 29 of the 47 exclusions were related to alleged Information Governance (IG) breaches. The report also noted that this increase in the number of exclusions had resulted in an increased use of agency staff to backfill in the areas where there was a high number of IG- related exclusion cases. This was to ensure that there was no negative impact on patient safety or staff morale.

The Committee noted that, due to increased number of exclusion cases, there was an increased focus on exclusion management with the current exclusion position being actively monitored alongside case progression. Steps had been taken to increase disciplinary panel capacity so the recent extended timescales for case management can be expedited. The Group, as required by NHSE, was taking a zero-tolerance approach to the IG breach issue and ensuring that each case was investigated speedily and resolved as appropriate.

The Committee was **reasonably assured** by the Employee Relations and Exclusions Report.

Assurances in respect of Objectives 2d:

a) Communications and Engagement Dashboard
b) Recognition and Staff Achievements Report
c) Wellbeing Reward

The Committee reviewed the September 2026 Communications and Engagement Dashboard (**attached**) and noted the various headlines. The headlines including the top 7 things raised in the month on staff closed Facebook pages, top news items, key internal messages for the month, and the forthcoming public engagement activities.

The Committee reviewed the revised Recognition and Staff Achievements Report and noted that it provided a comprehensive overview of staff achievements and recognition activity across the Group for the months of August and September 2026.

The Committee received a report titled 'Wellbeing Reward Incentive – 25-26 Evaluation and 26-27 Implementation'. The report informed the Committee that the 2025-26 Wellbeing Reward Day was introduced to recognise colleagues who completed four activities supporting workforce health, engagement, development and organisational performance. The four activities were the National Staff Survey, seasonal influenza vaccination, appraisal and statutory and mandatory learning. The report noted that the scheme had provided a credible engagement and recognition mechanism, supporting improved participation in some measures and helping to sustain already high levels of compliance in others.

The Committee noted that a total of 3,602 staff members, representing 28.72% of the Group workforce, ultimately received the additional wellbeing day. The Committee also noted the positive impact of the 2025-26 Wellbeing Reward Day and the key learnings that have informed the launch of the 2026-2027 Wellbeing Reward Day.

The Committee was **substantially assured** by the information that the 2026-27 scheme had been informed by a structured evaluation of its first year.

Assurances in respect of other areas:

a) Staff Story – ROAG Learning Case
b) ULTH Sonographer Workforce Planning
c) Board Assurance Framework
d) Risk Report including Risk Register
e) Thirlwell Report
f) Terms of Reference
g) Annual Board Report and Statement of Compliance for Professional Standards (Medical)

The Committee received and noted the positions in respect of the Staff Story, Board Assurance Framework and the Risk Report.

The Committee received a report which outlined the actions being implemented by the Group so it could have sustainably resilient Obstetric and Non-Obstetric Ultrasound Services. The aim of the actions was to convert the Group's training pipeline into to a substantive Sonographer workforce capacity, retaining specialist practitioners, and reducing reliance on insourcing without destabilising performance or training capacity.

The Committee noted that these actions were necessary because Sonography was a nationally recognised shortage workforce. The report stated that the workforce challenge was compounded by training timescales, retirement and attrition risk, increasing demand and the specialist nature of UK ultrasound practice.

The Committee was informed that the Group had a credible sonographer workforce plan with a current pipeline of six trainees, supported by annual training places, recruitment and retention premia, a structured career pathway and a British Medical Ultrasound Society (BMUS)-aligned preceptorship infrastructure. The plan however required support for a staged workforce trajectory that converts trainees into substantive capacity, protects senior/specialist skill mix, supports obstetric ultrasound requirements, and reduces reliance on insourcing.

The Committee:

- Endorsed the proposed workforce trajectory as a planning framework, subject to validation against local establishment, vacancy, trainee progression and demand data.
- Supported the implementation of recruitment and retention premium as both a recruitment lever and a retention risk control.
- Supported a staged and evidence-based reduction in insourcing only when internal capacity, skill mix and performance recovery allowed.
- Recognised obstetric ultrasound as a specific workforce risk because of Fetal Anomaly Screening Programme standards, screening pathway requirements, image review, the Down's syndrome screening quality assurance support service, urgent obstetric demand and the need for appropriately trained practitioners.
- Supported the development of a visible career pathway from trainee sonographer through consultant practice, supported by Clinical Specialist Practice Educator capacity and a BMUS-aligned preceptorship model.

The Committee received a report which noted the substantial work being undertaken in the Group to comply with the findings and recommendations from the Thirlwall Inquiry.

The report also highlighted the range of controls and arrangements already in place, including Freedom to Speak Up arrangements, the Safe to Say campaign, staff survey monitoring, leadership and culture development, wellbeing and mental health provision, safeguarding governance, and established patient safety and workforce reporting. The Committee sought assurance that these existing controls and arrangements adequately reflected

emerging learning from the Thirlwall Inquiry and requested ongoing updates as national guidance develops.

The inquiry had examined the events surrounding the crimes of former neonatal nurse Lucy Letby at the Countess of Chester Hospital and the wider leadership, governance, cultural and system factors that affected the recognition and response to concerns.

The Committee reviewed its Terms of Reference, which had been revised to include the new Deputy Director of People Programmes to the Committee's membership. The new role would be supporting the delivery of the Work Well programme, single entity transition and other significant people-related programmes.

The Terms of Reference had also been revised to change the title – Associate Non-Executive Director (ULTH) – to Non-Executive Director (ULTH).

The Committee approved the (**attached**) revised Terms of Reference for ratification by the Group Board.

The Committee received and noted the Annual Board Report and Statement of Compliance for Professional Standards (Medical).

The Committee noted that the areas requiring close monitoring were:

- Temporary staffing utilisation and associated expenditure.
- Delivery of workforce plan trajectories.
- Increased employee exclusions associated with Information Governance breaches.
- Acute appraisal compliance.
- Sonographer workforce sustainability.

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 None

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurance received by the People Committee
- note the attached September 2026 Communications and Engagement Dashboard
- ratify the revised People Committee Terms of Reference (attached)

Vicki Wells, Non-Executive Director (Chair)

16 October 2026

NHS
Lincolnshire Community and Hospitals NHS Group

Communications and Engagement Dashboard

September 2026



Group communications internal dashboard

Staff Facebook groups

10,264 members **2,487** comments **943** posts **9,516** reactions

Top things raised in the month on staff closed Facebook pages:

- Wellbeing reward
- Flu vaccinations
- Fuel prices
- Long service recognition
- Carparking around maternity in Lincoln
- Colleague thank yous, celebrations and goodbyes

Key internal messages for the month:

- Getting ready for launch of EPR
- Uniform portal
- Call for Concern expanding to Grantham
- Prof Ciro Rinaldi appointed Group Chief Medical Officer
- Your Voice – maternity and neonatal care
- Waiting List Validation project launching
- Black History Month
- Wellbeing reward
- Changes to the NHS e-Referral Service
- Changes to mobile phones requests
- Flu vaccinations launch
- Launch of attendance policy

Intranet usage: unique viewers: 11,907 | visits: 1,189,220

Top three visited sites

1. Web Based Applications
2. Datix
3. Clinical links

Top news items

1. EPR getting ready
2. Launch of Work Well Plan
3. Stay well at work – flu vaccinations

Group Bulletin

Wednesday 2 September – 2,572 views. Average read time: 3 minutes
Wednesday 9 September – 2,561 views. Average read time: 4 minutes
Wednesday 16 September – 2,281 views. Average read time: 3 minutes
Wednesday 23 September – 2,274 views. Average read time: 4 minutes

Snapcomms desktop pop-up and ticker messages

- **8** messages (including screensavers)
- Screensaver success (delivery rate) **62%**
- Desktop alert success **23%**
- Survey success **12%**

Top performing message: EPR first training countdown **23%**

Talk to ELT – Thursday 3 September

- **269** watched live
- **86** views on demand
- **Top themes** – Merger and Single Organisation, use of AI, Patient Services Hub

Group communications external dashboard

Eight proactive press release sent out:

- LCHG Staff Awards 2026 - announcing the shortlist
- Shaping our hospital and community services
- Families remember their loved ones with a memory tree at their local hospital
- Local family's marathon race to thank hospital ward that gave them their dad back
- Call for Concern 'Martha's Rule' service expands to Grantham and District Hospital
- United Lincolnshire Hospitals Charity celebrates 30 years of caring for local patients
- Charity Ball to raise funds for stroke patients
- Breast cancer patient inspires 55-mile charity challenge to transform care for future patients

One column:

- Our aspirations for the future of healthcare in Lincolnshire, column by Professor Karen Dunderdale Chief Executive

They can all be found on www.ulh.nhs.uk/news and on lincolnshirecommunityhealthservices.nhs.uk/latest-news

18 media enquiries were handled by the Communications Team.

102 stories appeared in media, relating to endoscopy unit in Lincoln, fundraising, for Lincoln breast unit, 30 years of hospital charity, urgent care services in Grantham, merger of LCHS and ULTH, hospital parking charges

Social media mentions included posts about CDC bus, fundraising for breast cancer unit, new endoscopy unit in Lincoln, stroke services location, new radiology equipment, patient's belonging missing, volunteering, NHS services in Grantham

Angler Chris reels in thousands for Lincoln Breast Unit in thanks for wife's care



Chris and Gudrun Frankish with Gudrun's consultant, Mr Thekkinki | ULH Charity

Breast cancer patient inspires 55-mile charity challenge to transform care for future patients



Columnists

COLUMN: Getting Lincolnshire's NHS ready for winter

Health – Cheryl Thomson, divisional managing director at Lincolnshire Community and Hospitals NHS Group



Families remember their loved ones with a memory tree at their local hospital



New service ensures concerns can receive urgent clinical review

Patients and their loved ones can now request an urgent clinical review if they fear someone's condition is unexpectedly deteriorating at a town hospital.

Lincolnshire Community and Hospitals NHS Group has introduced its Call for Concern service, also known as Martha's Rule, at Grantham and District Hospital.



Charity celebrates 30 years of caring for local patients

Linda Patrick

FOR 30 years, United Lincolnshire Hospitals Charity has provided care and support for patients, their families and staff who look after them across Lincolnshire's hospitals.

Since it was established on 17 September 1996, the charity has been helping to transform healthcare in Lincolnshire's hospitals, by funding the extras which cannot be provided by the NHS alone.

Chair of Lincolnshire Community and Hospitals NHS Group, Rebecca Brown said: "This wonderful charity has come a long way since it began supporting our hospitals in 1996. Today, more than 950,000 patients come through the doors of Lincolnshire's acute hospitals every year. For some this will be a new and daunting experience, for others it may be the start of a long journey



me can have this treatment. Being able to walk down the street and feel confident and not feel like everyone is looking at you is so important and empowering."

Thanks to the generosity of supporters, United Lincolnshire Hospitals charity has funded scalp cooling machines for hospitals in Lincoln, Boston and Grantham.

Reflecting on the charity's achievements, Rebecca added: "The 30th anniversary of the charity's service to the people of Lincolnshire is a time of celebration. Every patient and family using our hospitals has benefitted from our charity in some way, and we must ensure that United Lincolnshire Hospitals Charity continues to provide this unwavering support for the next 30 years. We would like to thank all our supporters for their kindness and generosity."

Throughout this 30th anniversary year, a series of fundraising events and activities will take place in support of

EDGE Completes £26.5m NHS Endoscopy Unit in Lincoln

Posted on September 14, 2026 in Project News



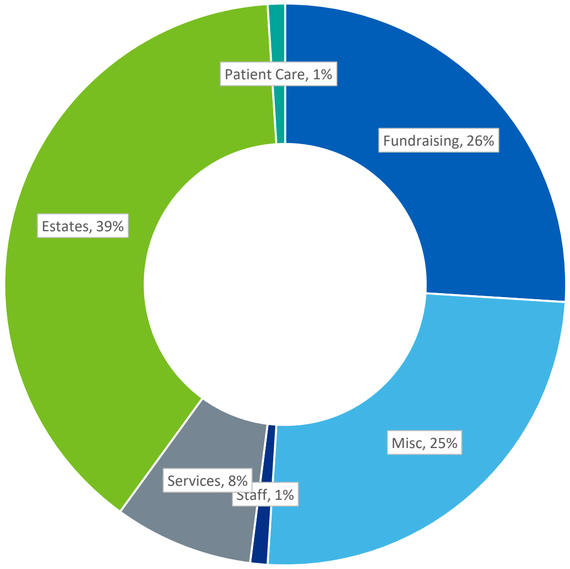
Hospital trust makes extra £675,000 from parking

BBC NEWS



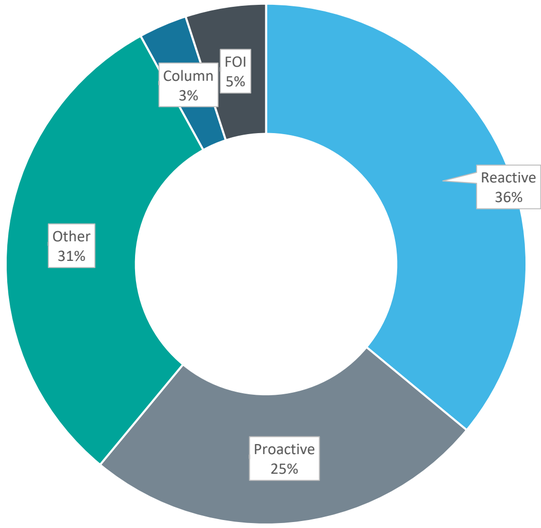
Theme

- Fundraising
- Misc
- Staff
- Services
- Estates
- Patient Care



Source of story

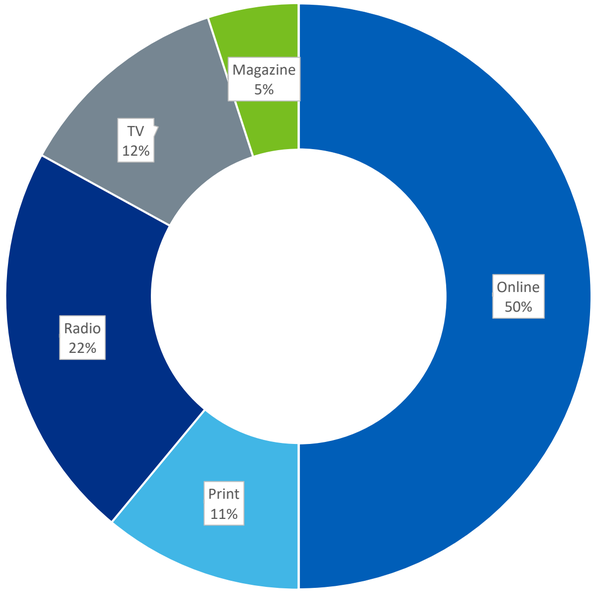
- Reactive
- Proactive
- Other
- Column
- FOI



- **Reactive:** Responded to a media enquiry
- **Proactive:** PR by comms team
- **Column:** Column written and submitted by comms team
- **Other:** Third party coverage - comms team not involved

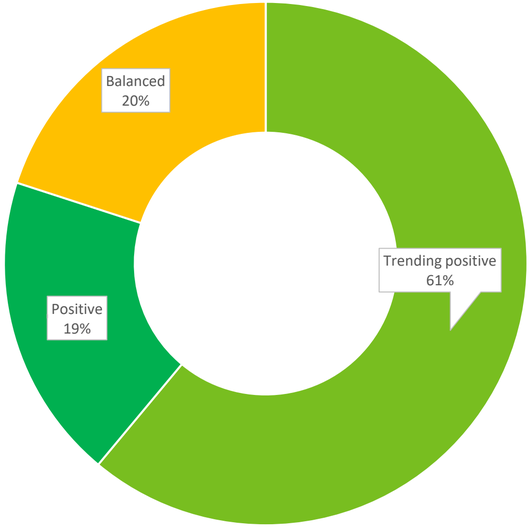
Media

- Online
- Print
- Radio
- TV
- Magazine



Sentiment

- Trending positive
- Positive
- Balanced



- **Positive:** Indicates favourable feelings.
- **Trending Positive:** Suggests a general upward shift in the positivity.
- **Balanced:** Represents neutral content where no strong positive or negative emotions are expressed.
- **Trending Negative:** Indicates a general downward shift or increase in negative opinion.
- **Negative:** Indicates dissatisfaction, criticism, or unfavourable opinions.

Group communications social media

YouTube
1.9K subscribers

Instagram
9,501 accounts reached
0.61% page engagement rate
6,395 followers
99 new followers
18 posts

Facebook
141,260 reach
7.59% page engagement rate
27,674 followers
218 new followers
39 posts

X
2,168 impressions
4.9 % post engagement rate
14,690 followers
9 fewer followers
2 posts

TikTok
145,674 accounts reached
0% post engagement rate
833 followers
85 new followers
0 posts

LinkedIn
2,689 impressions
9.05% page engagement rate
14,900 followers
123 new followers
11 posts

Websites
81,000 users
Top viewed pages: vacancies, MSK physiotherapy, Lincoln County Hospital, Johnson Community Hospital, John Coupland Hospital, phlebotomy

Key
Engagement rate: measures how actively our audience interacts with our content. The higher, the better.

Impressions: total number of times a post has been displayed to users.

Top social media posts



Award-winning patient care! 🎉 Our rapid access angina clinic team has won the Nurse-Led Patient Safety Initiative of the Year at the HSJ Patient Safety Awards 2026. Working alongside NHS Lincolnshire ICB, our cardiology, radiology and community diagnostic centre teams have transformed care for patients with suspected angina, offering faster access to appointments, same-day CT scans and results. This innovative service has cut waiting times by months, reduced missed appointments, helped prevent hospital admissions and improved outcomes for patients across Lincolnshire. A huge congratulations to everyone involved in delivering this fantastic service. #HSJPatientSafetyAwards #PatientSafety #TeamULTH



Our new corporate volunteers are hard at work. Huge shout out to the team from EE for giving your time freely to make our gardens at Lincoln County Hospital a more welcoming place to visit. We have more volunteering tasks that need to be carried out across Lincolnshire's hospitals at Lincoln, Boston and Grantham. Please drop us a line to see how your team can help transform healthcare for our patients, their families and our staff. ulth.charities.team@nhs.net



🚧 Progress update from Boston's new community diagnostic centre! These latest drone photos from the York Street site show the excellent progress being made on the groundworks for Boston Community Diagnostic Centre. Our construction partners, MTX Contracts, are currently working on the retaining wall along the north elevation (near Matalan), which will help raise the building and provide protection against flood risk. The pile caps and steel stubs have now been concreted into place, and the team is preparing to begin shuttering works to create the concrete base. Next month, we'll reach another exciting milestone when the steel structure of the building is delivered to site. Find out more about the Boston Community Diagnostic Centre and what it will mean for local communities: 🔗



NHS United Lincs
@ULHT_News

Are you waiting for a hospital appointment?
You may receive a text message asking you to confirm whether you still need your appointment.
✅ Quick to complete

⚠️ You won't be removed from the waiting list if you don't respond.

More info: ow.ly/4Icr50ZP7yK

Charity communications dashboard

Instagram
1,731 engagements
1.13% page engagement rate
494 followers
5 new followers
18 posts

Facebook
141,260 engagements
5.1% page engagement rate
3,400 followers
94 new followers
39 posts

X
1566 engagements
4.84% post engagement rate
1,080 followers
2 followers
2 posts

LinkedIn
82 page engagements
2,689 impressions
9.15% page engagement rate
1,361 followers
12 new followers
12 posts

Website
3,103 users

Key
Engagement rate: measures how actively our audience interacts with our content. The higher, the better.

Impressions: total number of times a post has been displayed to users.









#SupporterOfTheWeek A huge thank you to Laura, Julie and all the team Specsavers, Morrisons, Lincoln for raising over £1,000 in a week to provide nursing pillows, baby nests and other items that will help bring comfort to our tiniest patients on the neonatal unit at Lincoln County Hospital. They even bought new microwaves and goodies for our staff too!

Group engagement dashboard

Programme	Engagement Type	Reach	Status
Travel and transport (staff)	Survey	1,085 staff responses	Complete – unpublished.
SALT pre-school pilot (Wave 1)	Survey, drop-in, stakeholder input, EDI	Phase 1: 389 reached, 261 completions, 76 families, 66 professionals	Phase 1 closed published. Recommendations issued to the service. Phase 2 closed 09/08/26. Now being analysed.
Proposal to relocate Skegness UTC to CDC	Survey, site visits, public networking 12 week engagement	Survey open with 563 responses so far. In-person engagement activity planned for 22/10/26	Launched 10/08/26. Running until 30/10/26
Left shift and future direction engagement	Survey, public engagement events, targeted outreach. 12 week population-wide engagement exercise	Survey open with 724 responses so far. In-person engagement activity underway, with numerous stakeholders, PPG groups and individual patients	Launched 07/09/26. Running until 30/11/26
Travel and transport (public)	Survey + targeted engagement 12 week engagement		Planned TBC
Dermatology relocation	Survey + mixed methods 4 week engagement		Planned TBC
Sleep service review	Survey + co-design + mixed methods 12 week engagement		Planned TBC
Pilgrim hydrotherapy pool	Survey 12 week engagement		Planned TBC
New Trust name poll	Survey/ poll open for two weeks		Launch 05/10/26

People Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

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

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

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

3. Membership

The members of the committee are:

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

The following roles will be routine attendees at the Committee:

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

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

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

4. Attendance and Quorum

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

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

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

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

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

Observers will be permitted as agreed by the Chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The People Committee will:

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

7. Administrative support

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

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

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

8. Accountability and Reporting Arrangements

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

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

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

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

Approved: May 2026

Approved by: Group Board

Next Review Date: April 2027

Lincolnshire Community and Hospitals NHS Group



Communications and Engagement Dashboard

August 2026

Group communications internal dashboard

Staff Facebook groups

10,227 members **4,053** comments **979** posts **11,797** reactions

Top things raised in the month on staff closed Facebook pages:

- Friends and Family Test SMS messages
- Water levels in PHB carpark
- New staff uniform
- Future of Skegness UTC
- Heatwave – working conditions in offices
- Therapy dog visits to wards
- Staff Awards nominations
- Patient care

Key internal messages for the month:

- Work Well Plan launch
- Single organisation announcement
- Let's talk Left Shift
- ULTH EPR e-learning is now live and digital download updates
- Musculoskeletal service for colleagues
- ULTH Freedom to Speak Up anonymous form
- Patient Service Hub updates
- The future of urgent treatment services in Skegness
- Help us create safe, accessible spaces for breastfeeding and expressing colleagues
- TRS statement ready for viewing
- Recruitment training hub now live
- Staff fraud awareness survey

Intranet usage: unique viewers: 10,582 | visits: 1,069,593

Top three visited sites

1. Web Based Applications
2. Datix
3. Clinical links

Top news items

1. Launch of Work Well Plan
2. Patient Services Hub updates
3. ULTH EPR e-learning live

Group Bulletin

Wednesday 5 August – 2,558 views. Average read time: 4 minutes
Wednesday 12 August – 2,581 views. Average read time: 4 minutes
Wednesday 19 August – 1,979 views. Average read time: 4 minutes
Wednesday 26 August – 2,057 views. Average read time: 3 minutes

Snapcomms desktop pop-up and ticker messages

- **21** messages (including screensavers)
- Screensaver success (delivery rate) **39%**
- Ticker success **16%**

Top performing message: Grantham BCP 4/8/2026 **24%**

Talk to ELT – Thursday 6 August

- **301** watched live
- **264** views on demand
- **Top themes** – Patient Service Hub, EPR, Pinnacle House, IT support to Louth staff, staff wellbeing.

Group communications external dashboard

Four proactive press release sent out:

- Have your say on the future of urgent treatment services in Skegness
- Shaping the future of care together as one organisation and one team
- Angler Chris reels in thousands for Lincoln Breast Unit in thanks for wife's care
- Monday 21 September 2026 - LCHS and ULTH Annual Public Meetings

One column:

- Compassion recognised where it matters most, column by Nerea Odongo, Group Chief Nurse, Lincolnshire Community and Hospitals NHS Group

They can all be found on www.ulh.nhs.uk/news and on lincolnshirecommunityhealthservices.nhs.uk/latest-news

12 media enquiries were handled by the Communications Team.

77 stories appeared in media, relating to Grantham UTC provision, merger of LCHS and ULTH, new endoscopy unit opening, Skegness UTC move proposals, specialist radiology equipment, charitable fundraising for breast cancer unit , incontinence service waiting times, impact of heatwave, dementia wristbands

Social media mentions included posts about CDC bus, fundraising for breast cancer unit, new endoscopy unit in Lincoln, stroke services location, new radiology equipment, patient's belonging missing, volunteering, NHS services in Grantham





Chris raises £35,000 for breast cancer unit



Specialist technology is speeding up patient care



Health trusts announce merger to help 'shape the future of care'



Professor Karen Dunderdale

Fresh drawings shed new light on £25 million health centre on former Boston United football ground

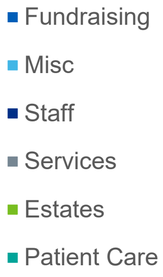


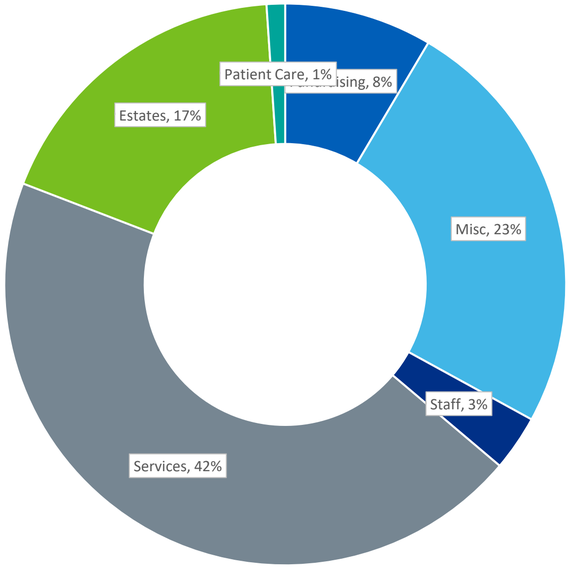
Call made for the return of hospital's A&E





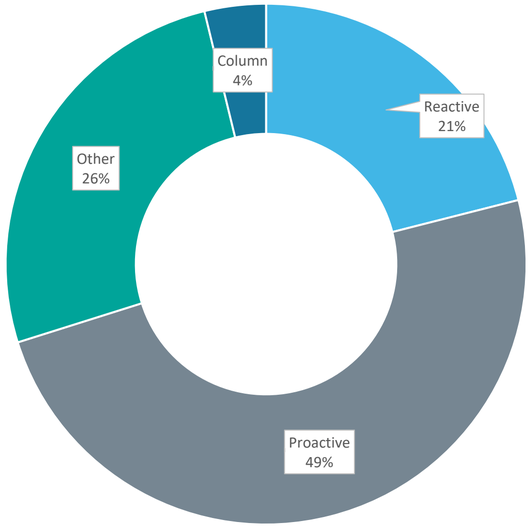
Theme





Source of story

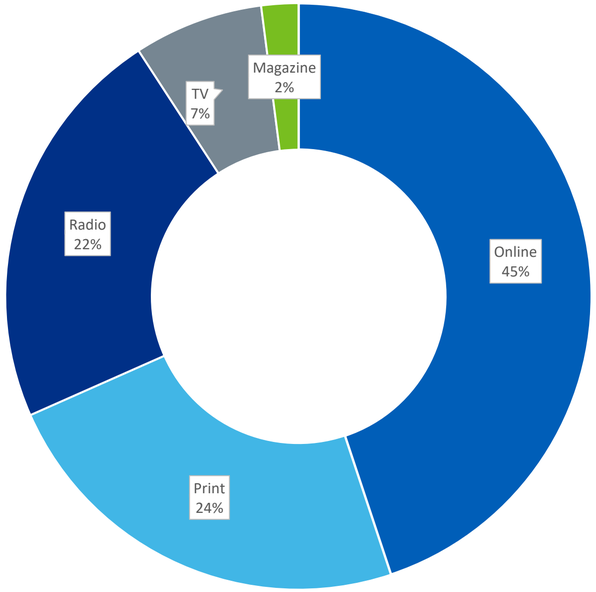




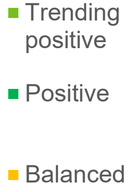
- **Reactive:** Responded to a media enquiry
- **Proactive:** PR by comms team
- **Column:** Column written and submitted by comms team
- **Other:** Third party coverage - comms team not involved

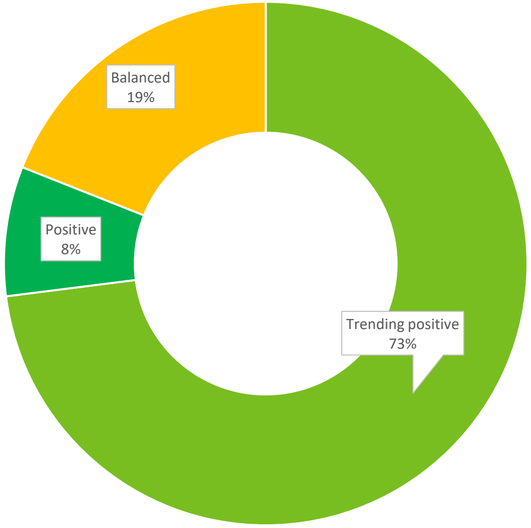
Media





Sentiment





- **Positive:** Indicates favourable feelings.
- **Trending Positive:** Suggests a general upward shift in the positivity.
- **Balanced:** Represents neutral content where no strong positive or negative emotions are expressed.
- **Trending Negative:** Indicates a general downward shift or increase in negative opinion.
- **Negative:** Indicates dissatisfaction, criticism, or unfavourable opinions.

Group communications social media

YouTube
1.9K subscribers

Instagram
8,503 accounts reached
16.57% page engagement rate
5,838 followers
63 new followers
14 posts

Facebook
89,358 reach
3.66% page engagement rate
24,222 followers
260 new followers
54 posts

X
1,182 impressions
0.98 % post engagement rate
14,120 followers
24 fewer followers
3 posts

TikTok
336,398 accounts reached
0% post engagement rate
748 followers
107 new followers
0 posts

LinkedIn
3,488 impressions
13.38% page engagement rate
13,418 followers
116 new followers
12 posts

Websites
79,000 users
Top viewed pages: vacancies, blood tests, Lincoln County Hospital, Johnson Community Hospital, John Coupland Hospital

Key
Engagement rate: measures how actively our audience interacts with our content. The higher, the better.

Impressions: total number of times a post has been displayed to users.

Top social media posts



Professor Karen Dunderdale, Group Chief Executive, recently visited our Macmillan and Specialist Palliative Care Nursing team. The team supports people with cancer or other life limiting conditions, who have complex physical and emotional needs that cannot being met by the patient's primary care providers in the community. The team is made up of clinical nurse specialists in palliative care, with a diverse mix of additional training in cancer, palliative care and nursing diverse groups in the community. #NHS #Macmillan #Palliative #Cancer #Lincolnshire #Nursing



On Monday, Professor Karen Dunderdale, Group Chief Executive, visited several teams at Lincoln County Hospital, which included: 💙 Patient advice and liaison service 💙 Medical examiners 💙 Clinical audit team 💙 Learning from deaths team. These teams provide a fantastic service which help keep our community and hospital services running.



Today, we have announced our intention to take a once in a generation opportunity to transform healthcare in Lincolnshire- by creating a new NHS organisation truly built around the needs of our diverse communities. We have announced our intention to formally merge Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and create a new, single NHS Trust to deliver both community and hospital services to the population of Lincolnshire. This will enable us to address the challenges we are facing now and transform how care is delivered for the future. Read more about our plans and aspirations on our website: https://www.ulh.nhs.uk/news/shaping-the-future-of-care-together-as-one-organisation-and-one-team/ #NHS #Lincolnshire



We are currently responding to a burst water main at Pilgrim Hospital in Boston. We are working on a solution to reinstate the water supply as soon as possible. Our advice to patients with appointments is to attend as usual unless we contact you to rearrange. (1/2)

Charity communications dashboard

Instagram
1,558 engagements
4.22% post engagement rate
491 followers
12 new followers
14 posts

Facebook
88,389 engagements
5.71% page engagement rate
3,313 followers
67 new followers
54 posts

X
1,246 engagements
4.83% post engagement rate
1,079 followers
-8 followers
3 posts

LinkedIn
191 page engagements
3,488 impressions
10.28% page engagement rate
1,350 followers
8 new followers
12 posts

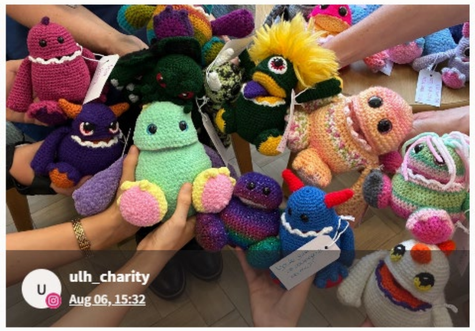
Website
2,769 users

Top posts



What do our new doctors need most when joining United Lincolnshire Teaching Hospitals NHS Trust? A mug from their hospitals charity that's what 😜 A huge welcome to our new foundation year 1 training doctors who are starting their training pathway with us. United Lincolnshire Hospitals NHS Trust - ULHT

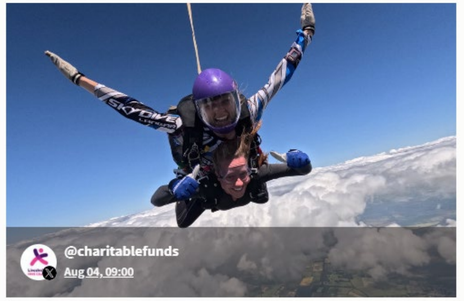
Top posts



Crochet creations have gone down a treat with our MacMillan Cancer Information and Support Service. Huge thanks to Olivia, Sophie and all their fellow crochet friends at Sir Robert Pattinson Academy for creating these wonderful woolly worry monsters. They will be given to children who are learning to cope with cancer in their family.



🚵 Our wheelchair hire scheme is a huge success at Lincoln County Hospital. In just one month the wheelchairs have been loaned out 334 times. And 27 lovely users have kindly made a donation to the charity totalling £95. It is so good to see our patients benefitting from the projects you support.



On the 19th of September, five of our brave staff are taking on a challenge like no other – our 30th birthday Skydive – to raise funds for Lincolnshire NHS Charity! 🪂 To get behind our amazing staff and donate, please follow the link below 👇
https://www.justgiving.com/campaign/lincsnhscharity30
https://twitter.com/lincsnhscharity/status/2084565070269292748/photo/1

Key
Engagement rate: measures how actively our audience interacts with our content. The higher, the better.

Impressions: total number of times a post has been displayed to users.

Group engagement dashboard

Programme	Engagement Type	Reach	Status
Sexual health (GLiSH)	Survey + targeted outreach	79 responses	Closed and published. Service implementing recommendations.
Group website development	Survey + feedback tool	157 responses	Complete – published. Service implementing recommendations.
Travel and transport (staff)	Survey	1,085 staff responses	Complete – unpublished.
SALT pre-school pilot (Wave 1)	Survey, drop-in, stakeholder input, EDI	Phase 1: 389 reached, 261 completions, 76 families, 66 professionals	Phase 1 closed published. Recommendations issued to the service. Phase 2 closed 09/08/26. Now being analysed.
Proposal to relocate Skegness UTC to CDC	Survey, site visits, public networking 12 week engagement	Survey open with 527 responses so far	Launched 10/08/26. Running until 30/10/26
Left shift and future direction engagement	Survey, public engagement events, targeted outreach. 12 week population-wide engagement exercise		Planned launch 07/09/26
Travel and transport (public)	Survey + targeted engagement 12 week engagement		Planned TBC
Dermatology relocation	Survey + mixed methods 4 week engagement		Planned TBC
Sleep service review	Survey + co-design + mixed methods 12 week engagement		Planned TBC
Pilgrim hydrotherapy pool	Survey 12 week engagement		Planned TBC

NHS
Lincolnshire Community and Hospitals NHS Group

LCHG Board Report – Information Governance Cases Overview

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*9.2*
Report title	*Information Governance Cases Overview*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance* • *Information*
Accountable Director	*Claire Low, Group Chief People Officer*
Author(s)	*Nico Batinica, Deputy Group Chief People Officer* *Jane Godfrey, Group Deputy Director of People*
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 content of the paper for information and assurance.*

Assurance Rating	***Description***
Green: Substantial	*Effective controls and appropriate assurances are in place*
Amber: Reasonable	*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	*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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	*X*
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	*X*
2c: Nurture compassionate and diverse leadership	*X*
2d: Recognising our people through thanks and celebration	
Population: Better Health – Improve population health:	
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	
3b: Move from prescription to prevention, through a population health management & health inequalities approach	
3c (i): Enhance our digital capability through innovation delivering the 10 year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Executive Summary

Given the scale of the exclusions, the potential impact on operational delivery and the level of public and regulatory interest associated with inappropriate access to confidential patient information, this paper provides the Board with assurance on the progression and governance of the Group's Information Governance employee relations cases. The paper focuses on 27 cases arising from suspected inappropriate access to patient records linked to two significant information governance incidents. Five cases have been determined as legitimate access with no case to answer, Seventeen investigations have been completed. Two disciplinary hearings have concluded, two are scheduled, seven require rearrangement following cancellation, six are being scheduled and five investigations are in the concluding stages. All cases are also scheduled for Professional Concerns Panel review.

The Group has taken a strong stance on these cases which reflects the national position which has been reinforced by Sir Jim Mackey, Chief Executive of NHS England. In his letter on unauthorised, inappropriate and unjustifiable access to confidential patient information. The letter states that such access is unlawful, seriously damages patient and public confidence and represents a failure of the NHS duty to protect patient privacy. It calls on NHS organisations to educate staff, take a firm approach where standards are breached, consider suspension as a neutral act where appropriate to protect the integrity of an investigation and minimise further risk, and act decisively when unlawful access occurs. In addition, the Group continues to reinforce Information Governance expectations through mandatory training, staff communications and ongoing awareness activities to reduce the likelihood of recurrence.

The principal risk to timely conclusion of these cases is hearing capacity and availability. Hearings are being arranged throughout October and November, with the aim of concluding the current programme by 30 November 2026. Seven panels have been cancelled due to representative availability, including some at short notice. Continued cancellations or postponements could result in hearings moving into December, prolonging uncertainty and extending operational and management capacity pressures.

The Group will work in partnership with Staff Side, particularly the Royal College of Nursing, to agree practical arrangements that protect the right to representation while improving the reliability of hearing dates. Substantial Assurance is proposed: governance and case progression arrangements are in place, but delivery remains dependent on sufficient panel and representative availability.

The Group's priority remains maintaining patient trust and confidence in the confidentiality and security of patient information whilst ensuring fair and proportionate treatment of colleagues involved in formal processes.

Board is asked to:
- Note the current position and planned progression of the IG employee relations cases.
- Note the planned October and November hearing schedule and the aim to conclude by 30 November 2026.
- Note the risk of slippage into December if cancellations or postponements continue.
- Support continued partnership working with Staff Side and the RCN.
- Receive Substantial Assurance, subject to continued oversight of hearing completion, case duration, exclusions and capacity.

Purpose and scope

The purpose of this paper is to provide Board with oversight of the current IG cases noting the progression of each case and how they are being managed, working in partnership with Staff side colleagues to conclude them as quickly as possible.

The Group recognises the personal impact that prolonged formal processes and exclusions may have on individuals and is committed to progressing cases as quickly as practicable whilst maintaining procedural fairness and welfare support.

Current IG case position

Measure	October 2026 position
IG programme cases	27
Legitimate access / no case to answer	5
Completed investigations	17
Disciplinary hearings conducted	2
Disciplinary hearings scheduled from completed investigations	2
Disciplinary hearings postponed and requiring rearrangement	7
Disciplinary hearings requiring dates	6
Investigations being finalised	5
Current suspensions recorded as IG-related	29 (2 unrelated to the 2 cases)

** As at 22/10/2026

The HR Process has moved from investigation into the disciplinary and hearing phase. The intention remains to progress cases without unnecessary delay, subject to panel availability, representative availability and the procedural requirements of each individual case.

Hearing cancellations and representation

Hearings are being arranged across October and November, with the aim of concluding the programme by 30 November 2026. Seven panels have been cancelled and require rearrangement, including some at short notice. Contributing factors have included representative availability and changes in representation arrangements. Continued cancellations or postponements could result in some hearings moving into December, prolonging uncertainty for the individuals concerned and increasing operational and management capacity pressures.

The Group recognises and supports the right of individuals to be accompanied at formal hearings. Individuals are advised at the outset of a case about representation, and this entitlement is reiterated when hearings are arranged. The Group will offer and facilitate representation at a hearing. The concern is not the exercise of the right to representation, but the operational and human impact of late changes and repeated postponement. Delay extends uncertainty for individuals, managers, witnesses and teams; prolongs suspension where applicable; uses scarce panel and HR capacity; and can affect confidence in the fairness and effectiveness of the process.

Proposed response and partnership action

The People Directorate will work with Staff Side, with specific engagement with the RCN, to develop a more reliable approach to scheduling while preserving representation rights. The proposed actions are:

- review the reasons for the seven cancelled panels and arrange new dates within 10 working days where possible;

- ensure hearing correspondence asks individuals to confirm representation arrangements and notify the case lead promptly of any change;

- consider with Staff Side whether provisional alternative representative arrangements can be identified where the preferred representative is unavailable;

- maintain a forward schedule of hearing dates across October and November, with active exception management where a case is at risk of moving beyond the end of November;

- record cancellations, reasons and notice periods to support oversight, escalation and learning;

- continue case-by-case consideration of postponement requests, balancing procedural fairness, individual circumstances and the need to avoid unreasonable delay.

Principal risks and Mitigations

Risk	Potential impact	Mitigation
Representative and panel availability	Further postponement, longer case duration and prolonged uncertainty	Early availability confirmation, forward scheduling, escalation and joint work with Staff Side and the RCN
Procedural fairness	Challenge if representation rights or reasonable requests are not properly considered	Clear advice from the outset, written confirmation and case-by-case decisions
Capacity and coordination	Pressure on trained panels, HR, commissioning managers and operational leaders	Programme oversight, prioritisation and continued panel training
Employee wellbeing and service impact	Extended suspension or unresolved proceedings may affect individuals and teams	Regular communication, welfare support, active case review and prompt rearrangement
Consistency and reputation	Variation or avoidable delay may reduce confidence in the process	Central oversight, decision records and consistent application of policy

Assurance assessment

Substantial Assurance is recommended because governance controls, investigation activity, hearing arrangements and oversight mechanisms are operating as intended. The principal challenge relates to scheduling and capacity rather than deficiencies in governance or process. Completed investigations are moving through the appropriate decision-making routes, and hearings are being arranged during October and November with the aim of concluding by 30 November 2026. Panel training is increasing capacity. The assurance position is moderated by ongoing delivery risk arising from panel and representative availability. Partnership work with Staff Side and the RCN is therefore an important control and will be monitored through established employee relations governance arrangements.

Mitigations are in place to manage the operational impact of exclusions and no material impact on patient safety has been identified through the management of these cases.

Failure to address inappropriate access to patient information effectively could adversely affect public confidence, regulatory confidence and the Group's wider information governance obligations.

The Group has identified the cases, established appropriate governance arrangements, progressed investigations, increased hearing capacity and is actively managing the remaining disciplinary process. Whilst delays arising from availability and scheduling remain a delivery risk, there is no evidence that governance arrangements are ineffective, and the programme remains on track to conclude the majority of cases by the end of November 2026.

Recommendations

The Board is asked to note the current position and planned progression of the IG employee relations cases and that hearings are being scheduled across October and November with the aim of concluding them by 30 November 2026.This will be subject to availability of representatives and panel members. However, Board should receive Substantial Assurance in relation to process governance and risk mitigation, subject to continued oversight of hearing completion, case duration, exclusions and capacity.

NHS
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Integration Committee Upward Report

Caring and building a healthier future for all

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

Integration Committee Upward Report of the meeting held on 24 September 2026

Accountable Director	*Daren Fradgley, Deputy Group CEO / Group Chief Integration Officer/*
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 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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	*X*
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	*X*

3c (iii): Enhance our research and innovation capability linked to our population health needs	*X*
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	*X*

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	Integration Committee
Report from meeting held on:	24 September 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 24 September 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) Diabetes & Endocrinology Left-Shift Transformation
b) Estates and Facilities Update including Key Risks
c) Palliative and End of Life Care Lead Provider Model Update
d) Better Flow, Better Care Delivery Plan and Programme Update

The Committee was **substantially assured** by a report that the Diabetes & Endocrinology Left-Shift Transformation Project had made strong progress in the steps to reduce unwarranted variation, and to build a modern, integrated Cardiovascular, Renal and Metabolic (CVRM) model of care. The project has brought together two aligned workstreams: One Workforce and GLP-1 Delivery Reform, supported by active co-production and strong Primary Care involvement.

The One Workforce workstream had mapping of pathways, workforce capability, service gaps and geographical variation, laying the foundations for a single integrated Diabetes and Endocrinology workforce model aligned to future CVRM ambitions. The GLP-1 workstream, on the other hand, has advanced the case for change and developed clear delivery options.

The Committee was informed that further pathway development had been paused until there was an update from the Derby and Derbyshire, Lincolnshire and Nottinghamshire (DLN) ICB cluster regarding alignment of commissioning arrangements across those three systems. This will prevent any unfunded or unsafe transfer of activity into primary or community care.

The Committee was **substantially assured** by an Estates and Facilities Capital Delivery update which highlighted strong progress across the major capital programme and wider estates transformation agenda. The report noted that the key aspects of the transformation agenda, property rationalisation and estate optimisation, remained key areas of focus for the Group.

The report noted that the NHSE had approved funding to the value of £48m for the Lincoln Maternity project. Steps were being taken to review the proposed building's design so that it is aligned with the approved financial envelope. The Committee also noted that the Skegness Council had approved a £600k contribution for a Social Well-Being hub located next to the Skegness UTC.

The Committee was informed that workload capacity remains challenging for the Estates team due to the number of projects that remained live and planned.

The Committee received a report which stated that Palliative and End of Life Care in Lincolnshire was undergoing significant review and redesign as part of the wider Derby and Derbyshire, Lincolnshire and Nottinghamshire (DLN) ICB Cluster strategic commissioning programme. The work was being driven by national expectations for ICBs to undertake needs assessments, strengthen commissioning arrangements and move towards more sustainable hospice and specialist palliative care models.

The report noted that the goal of the review was to remove the variations in access, workforce sustainability issues, and the gaps in specialist provision across Lincolnshire. The Committee also noted that the plan was for there to be stronger integration between community, hospice, primary care and hospital services in Lincolnshire. The Committee was informed that the Group had offered to act as Lead Provider for the planned integrated specialist palliative care model and was waiting for DLN ICB to confirm the role.

The Palliative and End of Life Care Lead Provider Model Update provided the Committee with **substantial assurance** about the progress being achieved.

The Committee received the Better Flow, Better Care Delivery Plan and Programme Update, which noted that the programme had been established across the Group. The report noted that delivery of the Programme was focused on improving patient flow and outcomes across the whole pathway from acute admission through discharge, intermediate care and community services. The Committee was informed that the programme had moved from initial mobilisation and diagnostic activity into detailed design and testing, with governance, executive leadership and workstream arrangements established.

The report advised that during September 2026, delivery was focused on three priority areas: ward processes, Transfer of Care Hub (TOCH) processes and intermediate care flow, underpinned by system visibility, effective system management and culture and organisational development.

The Better Flow, Better Care Delivery Plan and Programme Update provided the Committee with **reasonable assurance** about the progress being achieved.

Assurances in respect of Objective 3c(ii):

a) EDMS Programme Report
b) EPR Programme Report and EPR Go Live Assurance

The Committee received **substantial assurance** that digital services continued to deliver transformation. The report noted that the electronic document management system (EDMS) programme had successfully deployed MediViewer through Cluster 4, with the latest rollout completed safely and user feedback largely positive. The report stated that the lessons learned from the previous deployments will inform the remaining cluster deployments.

The Committee was informed that training compliance and adoption for Cluster 4 remain below the required level and was the most significant readiness risk for the remaining rollout of Clusters. Work was being undertaken to move EDMS training onto the Learning Management System, with the support of the Information Governance function.

The report stated that recent cluster deployments had created a significant amount of follow-up actions across clinical safety, information governance and operational assurance. The EDMS programme has therefore entered a planned 4 week pause so the training position could be recovered, and the other outstanding clinical safety and information governance actions could be closed. The report advised that after the outstanding actions had been completed and operational readiness had been confirmed, the recommendation was to retain 6th October 2026 as the target date for the deployment of Cluster 5.

The Committee received a report on the EPR implementation programme which stated that Go-live 1 was on schedule for 13 October 2026. The report stated that Technical Go-live was successfully undertaken on 07 September 2026, and that the relevant Go-Live Readiness Assurance Assessments had also been completed.

The Committee was **substantially assured** by the report and **endorsed** the readiness assessments.

Assurances in respect of Objective 3c(iii):

a) Research and Innovation (R&I) Group Upward Report

The Committee received a report which stated that research delivery remained active across acute and community settings. The Committee noted that although recruitment was currently below the profiled trajectory required to achieve the annual target of 2,004 participants, the research portfolio continued to deliver a substantial volume of recruitment activity.

To help address the current recruitment shortfall against target, an application had been submitted to the National Institute for Health and Care Research – Regional Research Delivery Network (NIHR RRDN) for additional research delivery support covering the period October 2026 to March 2027. This would support the opening of a clinical study and help make a significant contribution towards closing the current gap in recruitment performance.

The Committee was updated on the steps being undertaken with the support of the University's School of Pharmacy to train research pharmacists. This would help address the capacity challenges within the Group's small Research Pharmacy team.

The Committee noted and was **substantially assured** by the contents of the R&I Group Upward Report.

Assurances in respect of Objective 3d:

a) Productivity, Improvement and Transformation Oversight Forum (PITOF) Upward Report
b) Alliance Steering Group Upward Report
c) Update on potential new contractual vehicles to deliver neighbourhood health & NHSE consultation response

The Committee noted the PITOF report which provided **assurance** in respect of the programmes of work.

The Committee received the Alliance Steering Group Upward report which indicated that the Alliance portfolio continued to demonstrate positive progress across the transformation, neighbourhood health, and health inequalities agendas. The focus was increasingly shifting from programme mobilisation and transactional service transfers to delivery, benefits realisation, and measurable impact.

The report advised that while significant progress was evident, a number of workforce, commissioning and system-dependency risks remained that required continued executive oversight.

The Committee was **assured** by the Alliance Steering Group Upward report.

The Committee received an update on the implications of NHSE's Fit for the Future proposals for new neighbourhood contracting arrangements, including Single Neighbourhood Providers (SNPs) and Multi Neighbourhood Providers (MNPs). These proposals were intended to support population-based, outcome-focused commissioning and accelerate the shift of care from hospital to community settings.

The Group's analysis has indicated that the proposals presented both significant opportunities and risks for the organisation. The opportunities included strengthening the hospital-to-community shift, enabling more integrated neighbourhood care, improving population health management, and

positioning the Group as a potential lead provider or MNP. The risks included a potential loss of income and contractual control, fragmentation of services, transfer of activity without corresponding cost reduction, and the possibility of other organisations assuming strategic leadership of neighbourhood services.

The Committee was informed that the Group would continue to develop its readiness for the neighbourhood delivery models, maintain a leadership role in system transformation, and work through the Neighbourhood Health and Care Board to shape future arrangements rather than react to them.

The Committee noted the emerging opportunities and risks, endorsed the proposed preparatory actions, and noted the proposed five key strategic principles while national policy and consultation outcomes continued to develop. The proposed five key strategic principles the Committee noted were that:

i. The Group supports the strategic direction of neighbourhood health and the principle of population-based, outcome-focused commissioning.
ii. Lincolnshire should strongly retain the principle that neighbourhood contracting should be an enabler of Lincolnshire's agreed neighbourhood strategy, not the driver of it to avoid the danger that the MNP architecture becoming the programme.
iii. Any future MNP model should protect the sustainability of essential community and acute services and recognise the financial consequences of shifting activity from hospital settings.
iv. The Group should actively explore the strategic options available to it, including the potential role of LCHG as an MNP, major delivery partner or subcontracted provider.
v. The Group should work through the Neighbourhood Health and Care Board to develop a system-wide position on contracting, aligned to the Integrated Neighbourhood Team (INT) blueprint, neighbourhood footprints, outcomes, estates, digital/data and funding arrangements.

The Committee noted that the proposed 5 key principles provided a clear position without prematurely committing the Group to a set direction. The Committee also noted the Group's response to the NHSE consultation and was **reasonably assured** by the report.

Assurances in respect of other areas:

a) Patient Story
b) Showcase of Ideas from National Improvement Directors
c) Board Assurance Framework 2026/27
d) Integration Committee Performance/ KPI Dashboard
e) Risk Register Report
f) Integration Principles

The Committee received and noted the position in respect of the Patient Story, the update on the Showcase of Ideas from the National Improvement Directors

Group held in September 2026, the Committee Performance Dashboard and the Risk Register Report.

The Committee reviewed the Board Assurance Framework and noted the stretched capacity of the Integration Directorate, while the team was managing all the various programmes relevant to it.

The Committee received an assurance report related to the actions being implemented to mitigate the significant risks associated with Group's transcription and file management services provision. The actions were around step to deploy ambient voice technologies (AVT) as pilot solutions in 4 areas of the Group. The Committee was assured that the Group was fully compliant in all but 2 areas of a checklist, where there was partial compliance. The Committee also noted that a Data Protection Impact Assessment (DPIA) had also been completed to underpin the pilot AVT contract.

The Committee reviewed and approved the revised draft Integration Principles, which was a guide to the senior responsible officers of the work streams supporting the development of the Group's integration plans. The Committee was informed that these Principles had been updated as part of the work to develop a single organisation business case to support the steps to merge the Group's two Trusts. The Committee was assured that the principles had been developed to align with the overarching aims of the merger.

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

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

a) None

4.0 Matters for reporting / escalation to the Group Board

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

a) The Committee noted the stretched capacity of the Integration Directorate, while the team was managing all the various programmes relevant to it.

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 Integration Committee

Jim Connolly, Non-Executive Director
24 September 2026

Integration Committee
Terms of Reference

1. Authority

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

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

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

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

2. Purpose of the Committee

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

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

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

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

Population: Better Health – Improve Population Health:

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

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

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

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

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

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

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

3. Membership

The members of the committee are:

- Non-Executive Director (Chair)
- Non-Executive Director
- Associate Non-Executive Director
- Group Chief Integration Officer / Deputy Group Chief Executive
- Group Chief Operating Officer
- Group Chief Finance Officer
- Group Chief Medical Officer or Group Chief Nurse (as required)
- Group Chief Estates and Facilities Officer
- Group Chief Communications and Engagement Officer

The following roles will be routine attendees at the Committee:

- Group Director of Corporate Affairs or their representative
- PCNA Representative
- Group Deputy Chief Integration Officer
- Group Director of Strategy Improvement and Redesign

4. Attendance and Quorum

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

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

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

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

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

Observers will be permitted as agreed by the committee chair.

5. Frequency

The committee will meet monthly.

6. Specific Duties

The Integration Committee will:

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

- Seek assurance on the adequacy of plans to realise the group's ambition of addressing the wider determinants of health and health inequalities.
- Seek assurance for the operational performance and delivery of Out of Hospital Services delivering on Integrated Care.
- Ensure that proposed changes to services are being made on the basis of strong clinical evidence and best practice.
- Seek assurance in respect of delivery of the group's digital agenda and objectives including development of the 'Vision for Information'.
- Review and seek assurance on delivery of the estates strategy, estates rationalisation & space management and sustainability & the Green Plan (including Net Zero) programmes of work.
- Ensure that key enablers to the delivery of the integration agenda are properly considered as part of the agreement of the group integration plan and programmes of work and that these plans and programmes of work are appropriately aligned to the longer term strategy, vision and values for the group.
- Review and provide assurance to the Group Board on those strategic objectives within the Board Assurance Framework, identified as the responsibility of the committee, seeking further assurance and actions where necessary. This may include the commissioning of 'deep dives' to identify the necessary improvements and actions.

7. Administrative support

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

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

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

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

8. Accountability and Reporting Arrangements

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

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

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

9. Monitoring effectiveness and Compliance with Terms of Reference

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

10. Review of Terms of Reference

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

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

Approved: May 2026

Approved by: Group Board

Next Review Date: April 2027

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 November 2026*
Agenda item number	*10.1*

Integration Committee Upward Report of the meeting held on 23 October 2026

Accountable Director	*Daren Fradgley, Deputy Group CEO / Group Chief Integration Officer/*
Presented by	*Jim Connolly, Non-Executive Director*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Recommendations / decision required	*The Committee 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 whilst addressing our requirements for sustainability and our Green agenda	
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	
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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	*X*
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	*X*

3c (iii): Enhance our research and innovation capability linked to our population health needs	*X*
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	*X*

Board Committee Upward Report to the Group Board

Report for meeting of the Group Board to be held on:	03 November 2026
Report from:	Integration Committee
Report from meeting held on:	23 October 2026
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Integration Committee at its meeting held on 23 October 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) Patient Services Hub update – verbal
b) Better Flow, Better Care Delivery Plan
c) Estates Operational Delivery Plan
d) Estates and Facilities Update
e) Premises Assurance Model (PAM) Annual Self-Assessment
f) Continuous Planning updated to inc Sustainable Service Reviews

A verbal update was offered to the Committee in respect of the Patient Services Hub where it was noted that recruitment to roles was expected to be complete by the end of November and call abandonment rates were holding between 9-14%, compared to the previous 60%.

Improvements were noted in respect of outpatient and theatre bookings being made up to week 4 and week 4 respectively. Booking to 6-weeks was anticipated to be achieved by the end of November. It was noted that the letter backlog remained a challenge with a solution anticipated to be online the following week. A report would be offered to the Committee in November in respect of this.

Reasonable assurance was provided to the Committee in respect of the Better Flow, Better Care programme of work with early signs of improvement being seen through the 3 pilot wards. A further 11 wards would be rolled out which would continue to drive improvement. It was recognised that the programme of work had commenced 1 September 2026 rather than 1 April

2026 and therefore the calendar profile was misaligned resulting in consideration of the timing of the removal of the 56 beds.

The anticipated cost saving of £3.5m would be profiled in response to the timing of the programme of work with a commitment to reduce the number of beds by the end of March 2027. The Committee supported the Executive position to not remove beds before or during winter to prioritise patient safety and reduce congestion at the font door. Whilst there was **no assurance** in respect of the delivery of the £3.5m saving at this time all non-recurrent mitigations were being explored which would translate to recurrent savings at the point of beds being closed.

The Committee received and **commended** to the Board the Estates Operational Delivery Plan with **substantial assurance,** noting the development of this through structured engagement from patients to the Board. The plan would mobilise delivery through an established programme structure and clear reporting through the governance routes. The plan would allow the strategic development of business cases and would ensure that oversight of affordability, risk service transformation and system dependencies could be maintained.

Substantial assurance was received through the Eastes and Facilities update with progress noted in respect of the NHS Property Services transfer and the conclusion of the business case in the coming weeks.

The Committee noted the update in respect of the Pilgrim ED build and the work taking place by the external water expert to support the opening of the site. The number of transformational schemes being supported by the team were noted and an update on the Salix decommissioning programme at Pilgrim advised that the programme of work was at the halfway point with a current underspend of £20k.

The Premises Assurance Model (PAM) offered **reasonable assurance** to the Committee with recognition that there had been significant changes in the scoring methodology from previous years. There had been the inclusion of additional questions covering Martyn's Law and Helipad compliance with work taking place to address the requirements. The Committee was assured that the position of the PAM included the planned preventative maintenance backlog and associated action plans with regular review of the position.

Reasonable assurance was offered through the continuous planning update with the Service Sustainability Reviews having assessed acute epilepsy, orthodontics, neurology and rehabilitation medicine. Reviews were now embedded within the continuous planning cycle, and existing risks were being managed. The issues relating to the orthodontic service were noted by the Committee with recognition that this was being addressed through the appropriate governance routes.

Assurances in respect of Objective 3b:

a) District Nursing Framework: Referral to Discharge Framework

The Committee received the Referral to Discharge Framework with **reasonable assurance** and endorsed the executive approval and operational implementation of the framework across all District Nursing teams. It was noted that the framework provided a single standard for referral, first contact, caseload management, quality assurance and discharge. The implementation of the framework would support the future skill-mix review.

Assurances in respect of Objective 3c(i):

a) Digital Oversight Group Upward Report

Reasonable assurance was offered to the Committee with the recognition of the pressures currently on the digital teams as a result of the volume of transformational work underway. The Committee sought to understand the clinical digital safety capacity of the team due to the programmes of work with confirmation that there was resource in place.

Assurances in respect of Objective 3c(ii):

a) Digital Planning and Delivery Update inc EDMS
b) EPR Update

Substantial assurance was received in respect of the Electronic Document Management System roll out with support in place to ensure staff were trained ahead of go live 5. There was recognition of the operational pressures on health records and the scanning aspects with challenges experienced with paper records being returned from wards for processing, alongside loose-leaf filing presenting risks outside the scope of the programme of work. This position was being managed however a sustainable solution was required through the rescoping of the programme.

The Electronic Patient Record update offered **substantial assurance** following the first successful go live on 13 October 2026 for the flow and patient safety bundles. The risks present prior to go live, training, clinical hazard and regional assurance had been addressed and a strong presence from floor walkers had supported staff and enabled prompt resolution of any identified issues.

Learning was noted in respect of overheating hardware and the timelier need for Careflow updates to be made to ensure patients were visible with NerveCentre however lessons were learnt and responded to. A hot debrief had taken place post go live and an operational audit would be undertaken following a settling in period.

Assurances in respect of Objective 3c(iii):

No items due

Assurances in respect of Objective 3d:

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

The Committee received the Alliance Steering Group upward report noting **assurance** on the continued progress across the left-shirt programmes of work. Future reporting would be strengthened in order to differentiate between service movement and pathway changes.

The Committee received the final signed Primary Care Network Alliance Collaborative Agreement, recognising this as the enabler for neighbourhood health readiness and left-shift delivery.

The PITOF report was take as read with the Committee noting that **assurance** was offered in respect of the programmes of work however recording of benefits, milestones and financial profiles would strengthen with the use of Monday.com.

Assurances in respect of other areas:

a) Patient Story
b) Board Assurance Framework 2026/27
c) Committee Performance Dashboard
d) Risk Register
e) Pathology Service Transformation Risk Reprofile - Verbal
f) Policy Position Update

The patient story was received in relation to the Skegness Community Diagnostic Centre where a patient required specialist blood tests and ECG prior to commencement of immunotherapy. The Committee noted the compassionate integrated response to the patients needs where the tests were undertaken within 90 minutes of the GP appointment and the transfer of results supported to the oncologist to ensure treatment could commence.

The Committee received the Board Assurance Framework noting the updates and recognising that risk and assurance ratings remained as reported. It was recognised that the EPR go-live would need to be reflected within the BAF at the next round of updates.

The performance dashboard was received with **reasonable assurance** and continued attendance, and admission avoidance was noted to be performing well. Length of stay continued to be an area of concern with delays experienced against predicted dates of discharge, transitional care beds and no criteria to reside.

The Committee was **assured** by the updates provided in respect of the risk register noting the increase in 1 very high risk for LCHS, related to the overarching cyber risk which was now reflected across both organisations. Risks outside of appetite were noted to align to the reports received by the Committee.

The Committee noted the established pathology service transformation with strategic discussions taking place to ensure the Group was embedded in the process.

The policy position report was received with **reasonable assurance** with progress being noted in respect of documents being assigned to care groups and the archiving of obsolete/superseded documents. The compliance for corporate documents was noted alongside the work to identify documents that could be developed ahead of single entity on 1 April 2027.

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

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

a) None

4.0 Matters for reporting / escalation to the Group Board

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

a) None

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

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

a) None

6.0 Group Board Action Required

6.1 The Group Board is asked to:

- note the discussions and assurances received by the Integration Committee

Jim Connolly, Non-Executive Director

23 October 2026

NHS
Lincolnshire Community and Hospitals NHS Group

EPR Programme Report

Caring and building a healthier future for all

Meeting	*Lincolnshire Community and Hospitals Group Board*
Date of meeting	*3rd November 2026*
Agenda item number	*10.2*
Report title	*EPR Programme Report to Trust Board (Nov 26)*
Report purpose: • *Discussion* • *Approval* • *Assurance* • *Information* • *Other – please insert details*	*This report provides an update on the status of the EPR Programme two weeks post Go-live (1)* *This document is for information and assurance.*
Accountable Director	*Daren Fradgley – Programme SRO*
Author(s)	*Keith Dibble EPR Programme Director (Engagement)* *Stephanie Spencer – EPR Programme Director (Delivery)*
Assurance rating: • *Substantial assurance* • *Reasonable assurance* • *Limited or no assurance*	*Substantial Assurance*
Prior approval process, if applicable	*Elements of this paper have been shared with ELT, GLT, Integration Committee and NHSE.*
Financial implications, if applicable	*There are no specific payment implications at present.*
Action / decision required	*The Board is asked to:* • *note the contents of this report.*

x

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

Executive Summary

EPR Go-live 1 was activated on schedule on 13th October.

This report provides a status report based on the first two weeks, and Trust Board is asked to recognise that this position is still fluid, and therefore the assessment is only accurate at a point in time.

However, overall, the Go-live proceeded very well, and the issues identified have either been common to most EPR implementations, for example system access difficulties, or have been addressed quickly, even if short term solutions have been required, although we have endeavoured to avoid “knee -jerk” reactions, mindful of the need to maintain clinical safety and to allow staff time to become used to the new systems.

This report focusses largely on the first Go-live, suffice to say that progress on Go-lives 2 and 3 is being maintained, and the Programme overall remains on Amber.

Programme overview – summary

While Go-live 1 is now Green, as we have achieved Go-live, the Programme overall is Amber, which is expected at this stage, although both of the later Go-lives are progressing well.

There are some challenges in relation to Go-live 2 and interfaces with aspects of the EPMA module, but options are being considered in conjunction with the Nervecentre Team. We are confident that a solution will be agreed with no detriment to the Go-live schedule.

Challenges in relation to the expenditure and Benefits profiles, but significant progress has been made in both areas.

Details in relation to Go-live 1 are provided in section 3 below.

Section A – Go-live 1

1. Go-live Approvals

We worked closely with NHSE to meet the Regional and National Assurance framework designed to demonstrate that the Go-live was clinically and operationally safe. As this first Go-live was deemed to be low impact, we did not need to go through the full formal assessment in this regard, but it should be noted, that we are likely to have to do so for Go-lives 2 and 3.

However, we presented a narrative summary document to NHSE, together with some supporting documents, including the action plan created in response to the recommendations included in a report from NHSE following an assessment review in July.

The internal Authority to Proceed (AtP) was given by Steering Group on 7th October, based on a wide range of Go/No-Go criteria, and indicate the breadth and depth of assurance required to approve a Go-live, from operational readiness to clinical safety, and technical preparedness to the management of the go-live period itself.

The final and formal endorsement by the Regional Steering Group (RSG) on behalf of NHSE was received on 12th October.

The endorsement (from RSG) was conditional indicated, and we were able to assure RSG, via a formal letter from the CEO to the NHSE Regional Director, that:

1. We had completed all the pre-Go-live actions arising from the NHSE Assurance Assessment in July

2. The Clinical Safety Report has been formally signed off.

3. We have a robust pack of cutover, business continuity, downtime, recovery, and escalation plans, all of which have been signed off by the Steering Group and our Group Leadership Team.

4. The Trust Executive has been fully briefed and sighted on the risks and mitigations associated with this first Go-live.

5. The Authority to Proceed was signed-off formally at the Programme Steering Group meeting on 7th October, at which Nervecentre and NHSE colleagues were present.

6. We would monitor the impact of any Go-live on clinical activity, and micro-manage the process over the first 48 hours in particular via a full Command Centre Structure.

7. We would provide a daily written update summarising progress, issues and remedial action.

Through the Go-live period, we were able to demonstrate that we met all the criteria, and particularly, that there were no operational or clinical safety issues.

2. Training

The key challenge faced in the period up to Go-live was the need to have trained sufficient staff to ensure that the transition was safe.

The Trust set a safe target of 80% training for Go Live. This was overachieved at the point of Go Live by 85.6%.

3. Current position – post Go-live – challenges and successes

Thus far, we have had two excellent weeks with (mainly) minor issues being resolved as they are found. The levels of immediate support in all operational areas made a huge difference.

Staff engagement and support

The initial feedback across the organisation is generally positive, although of course, there is a degree of wariness at the change. We will conduct a full staff survey next month, so we can evaluate the views of staff in detail, and apply any learning required in relation to our planning for Go-live 2.

However, a major success in the Go-live process was the on-site support we provided to front-line staff via a comprehensive floor walking team, made up of Trust staff – digital nurses, our PMO team, and 50 (at peak) external floorwalker. Collectively, they became known as the “pink people,” due to the pink t-shirt given to all to identify them to the nursing and medical staff. It was this team, which enabled us to respond to issues quickly, either directly at the time or via an escalation process – to the service desk and the Command Centre.

While it is difficult at this stage to quantify the position in terms of staff adoption of the system, the key numbers below, illustrate the fact that the organisation is embracing the change - noting that these are cumulative, and accurate as of 23rd October.

The access summary figures now read as (with the figures in brackets reflecting the position on October 16th):

- 37210 (10,407) log ins
- 43, 635 (9584) Obs taken
- 51,143 (8534) completed assessments
- 113, 813 (30,593) clinical note updates
- 714 (192) Sepsis Think tests
- 25, 996 (3655) fluid balances

Overall, we remain comfortable with position we are in part in as we transition into BAU – see below. However, we continue to monitor issues as they arise and are committed to speedy resolution where possible.

4. Governance

We have been reporting our progress daily to NHSE/RSG, and this will continue for the two-week period from 13th October, and those reports have reflected the updates from Tactical/Strategic Command Meetings. These reports are for information only primarily, although the information relates to the conditions applied to RSG approval of our Go-live.

The Command Centre structure remained in place for the same period, although it transitioned into virtual mode after Day 4, while full on-site support continued, via floor walkers et al. for a full two weeks. We have now moved from “Hypercare” into “Early Life Support,” which is effectively a hybrid BAU model, with some enhanced Programme Support.

To ensure that the skills have been embedded and support has been retained, an audit round will be undertaken at the end of October in all areas with the results reported to Integration Committee. A second embedding audit will then be repeated in the same areas in Dec / January to assess progress and identify any residual risks. This will be in additional to thematic monitoring through support and helpdesk channels.

5. Next steps

Apart from the staff survey referred to above, we will work with Nervecentre through the Optimisation phase over the next month, during which will work in partnership with our supplier to address issues as they arise to create a period of stabilisation. This will be evidence based, partly because it is simply good practice, and partly because the outcomes from this period feed directly into the next Payment Milestone. In that regard, we will continue to audit both technical and access issues, working via the Operational Readiness Group to ensure system adoption and a smooth transition to BAU.

In so doing, we will continue to encourage ideas from staff in relation to system improvement, while in so doing managing expectations, as we need to stabilise, and in many cases, those ideas will be met by future Go-lives.

We will also undertake a full lessons learned exercise, partly internally as well as in conjunction with Nervecentre.

The outputs of this will feed directly into our planning for Go-live 2, as the time between the tranches is not significant, if we are to adjust our approach in any aspect of the planning or delivery.

Section B – Wider Programme Matters

6. Resourcing

Work continues on reducing Programme costs, and further staffing changes will be made once Optimisation is complete. Work also continues on the delivery of Programme Benefits. Details on both of these areas of work will be included in next month's report.

7. Communication and Engagement

The focus currently has been on Go-live 1 related issues, but we will undertake a post Go-live staff survey in approximately six weeks, and a broader engagement plan will be re-enacted.

8. Risk Assessment

The key risks are unchanged from the last report to IC, with that related to training.

- The revised timeline for Go Live 3 remains a delivery risk due to the compressed design and configuration phase.

- Resourcing also remains a key risk. This is being actively managed but requires continued focus, particularly given the financial position.

- The previous delays in the Go-live 3 timetable have highlighted the need for greater cohesion across the Trust in terms of developments, and the importance for inter-dependencies to be recognised. Recent developments in relation to PSH have served to re-emphasise this and continue to be of concern given the ongoing pause to that programme, and the strength of feeling expressed by some groups of staff.

9. Conclusions

Trust Board is asked to receive this report as an update on the first Go-live. A full and formal report will be presented to Steering Group in November.

NHS
Lincolnshire Community and Hospitals NHS Group

Group Board Performance Dashboard October (September Data)

Caring and building a healthier future for all

Meeting	*LincoInshire Community and Hospitals Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*11*
Report title	*Group Board Performance Dashboard*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Information* • *Assurance*
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	• Reasonable assurance
Prior approval process, if applicable	
Financial implications, if applicable	
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 whilst addressing our requirements for sustainability and our Green agenda	

People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	*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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	
3c (iii): Enhance our research and innovation capability linked to our population health needs	
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	

Executive Summary

Please note the People Committee section has been removed from the Board report due to the dashboard remaining under development and will be incorporated once finalised.

Overall performance at Month 6 remains mixed, with the Finance Committee score at 2.28, the Integration Committee scorecard at 2.27 and the Quality Committee report at 2.16. Community unplanned care, community planned care and acute quality remain the strongest areas, while acute planned care continues to record the highest section score at 3.00

Quality and Patient Safety

Acute quality measures remain comparatively stable overall. Falls resulting in moderate or severe harm reduced in September, while mortality remained consistent with its established trend.
Acute pressure ulcers increased during the latest period, particularly category 4 ulcers, following several months at lower levels.
Community category 3 pressure ulcers improved, falling from 73 in August to 56 in September.
Category 4 pressure ulcers moved in the opposite direction, increasing from 8 to 13.
The community complaints rate increased sharply during September to 4.71 per 1,000 WTE, following lower levels over the preceding months

Urgent and Emergency Care
Community UTC four-hour performance reduced to 95.36% following the improvement seen earlier in the summer.
UTC 15-minute triage performance also fell to 91.90%, while ambulance handover performance recovered strongly to 93.18% following the previous month's reduction.
Acute ED four-hour performance remained broadly stable at 77.94%, close to the 78% target.
EMAS conveyances completed within 45 minutes reduced to 75.63%, while the proportion of triage data not recorded increased to 0.47%.

Planned Care and Cancer
The acute waiting list reduced slightly to 69,989 and moved closer to the target of 69,003.
The proportion of incomplete pathways within 18 weeks improved to 63.00%, continuing the gradual upward movement seen over recent months.
The number of patients waiting more than 52 weeks increased to 1,089, reversing part of the improvement achieved earlier in the year. Patients waiting more than 65 weeks reduced to four.
The position for waits exceeding 104 days remained broadly stable at 131 following sustained increases across the year.
Faster diagnosis performance improved during September, while 31-day treatment performance increased to 92.88%. However, 62-day treatment performance reduced to 59.66%.
Diagnostic performance improved to 47.77%, representing a modest recovery following the downward trend recorded since the start of the financial year.
Community length-of-stay reduction increased from 243 days in August to 272 days in September, although it remained below the levels recorded earlier in the year. Community 18-week performance improved and 52-week performance remained broadly stable at 99.95%.

Workforce

Acute appraisal compliance continued its recovery, increasing to 68.29% after the significant reduction earlier in the year.
Acute mandatory training declined to 91.63%, although it remained above the 90% target.
Acute sickness absence continued its upward trajectory, reaching 5.75% in September.
Community mandatory training improved for a second consecutive month to 87.61%, recovering from the marked reduction recorded in July, but remaining below earlier levels.
Community sickness absence increased notably to 7.63%, continuing the deterioration seen over recent months.
The community vacancy rate continued to improve, reducing to 8.09%, while workforce turnover remained stable and below its target.

Overall Position
The latest data shows a combination of recovery and deterioration rather than a consistent movement across the dashboard. Improvements are evident in acute appraisals, community mandatory training, community vacancies, ambulance handovers, acute waiting-list size and elements of planned-care performance. These are balanced by rising sickness absence, reductions in UTC performance, increased community complaints, growth in 52-week waits and continued volatility across cancer and diagnostic measures.

The revised narrative deliberately emphasises month-on-month direction and longer-term movement, with the detailed causes, actions and mitigations left to the supporting exception reports.

Range	Colour	Description
1.00 - 2.00	Green	Performing Well/On Track
2.01 - 2.99	Warm Amber	Slightly Below Expectations
3.00	Burnt Orange	Performance Concern
3.01 - 4.00	Red	Underperforming

Group Board Report M6

Lincolnshire Community and Hospitals NHS Group

Overall Summary

Finance Committee	Integration Committee Scorecard	Quality Committee Report
2.28	2.27	2.16

Finance & Performance

Community - Unpl…	Community - Fron…	Acute - Front Doo…	Acute - Planned 4	Acute - Unplanne…	Community - Plan…	Group - Finance 7
1.77	2.43	2.50	3.00	2.63	1.94	2.35

Integration

Community - Unplanned 1	Acute - Front Door 2	Acute - In Hospital 3	Community - Planned 4
2.08	2.17	2.69	2.23

Quality

Clinical Effectiveness 7	Patient Safety 8	Patient Experience 9
2.07	2.17	2.22

Range	Colour	Description
1.00 - 2.00	Green	Performing Well/On Track
2.01 - 2.99	Warm Amber	Slightly Below Expectations
3.00	Burnt Orange	Performance Concern
3.01 - 4.00	Red	Underperforming

Group Board Report M6

Lincolnshire Community and Hospitals NHS Group

Acute - Quali…	Community -…	Acute - Work…	Community -…	Community -…	Acute - Fron…	Acute - Plan…	Acute - Unpl…	Community -…
1.70	2.14	2.30	2.50	1.88	2.50	2.80	1.50	2.00

Metrics Out of Range

Section Name	Org Name	Metric Name	Value	Target	LCHG Score
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Sickness Absence	5.75%	5.40%	3.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Mandatory Training	87.61%	90.00%	3.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Sickness Rate	7.63%	4.81%	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 104+ Day Waiters	131	10	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Diagnostics achieved	47.77%	99.00%	3.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Cancer - 62-day Treatment (Combined)	59.66%	85.00%	3.50

Information on Scoring Methodology

Report Summary Page

Lincolnshire Community and Hospitals NHS Group

Metrics for Awareness

Section Name	Org Name	Metric Name	Value	Target	LCHG Score
Acute - Quality	United Lincolnshire Teaching Hospitals	Acute - Complaints investigated and responded to within agreed timescales	80.00%	100.00%	2.50
Community - Quality	Lincolnshire Community Health Services	Patient Experience - Complaints - Rate per 1000 WTE	4.71	2.62	2.50
Community - Quality	Lincolnshire Community Health Services	Patient Experience - Duty of Candor (Verbal)	88.00%	100.00%	2.50
Community - Quality	Lincolnshire Community Health Services	Patient Experience - Duty of Candor (Written)	96.00%	100.00%	2.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Overall percentage of completed mandatory training	91.63%	90.00%	2.50
Acute - Workforce	United Lincolnshire Teaching Hospitals	Acute - Staff Appraisals	68.29%	90.00%	2.50
Community - Workforce	Lincolnshire Community Health Services	Workforce - Vacancy Rate	8.09%	6.99%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - 15 Minute Ambulance Handover	93.18%	95.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - 15 Minute Triage Compliance - Monthly	91.90%	95.00%	2.50
Acute - Front Door	Lincolnshire Community Health Services	UTC - Monthly 4 Hour Performance	95.36%	98.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	ED - % EMAS Conveyance Delayed <45 mins	75.63%	95.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	ED - % Triage Data Not Recorded	0.47%	0.00%	2.50
Acute - Front Door	United Lincolnshire Teaching Hospitals	ED - 4 hour performance	77.94%	78.00%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 18 week incompletes	63.00%	84.10%	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 52 Week Waiters	1089	486	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - 65 Week Waiters	4	0	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Acute - Waiting List Size	69989	69003	2.50
Acute - Planned	United Lincolnshire Teaching Hospitals	Cancer - 31-day Treatment (Combined)	92.88%	96.00%	2.50
Community - Planned	Lincolnshire Community Health Services	Community Waiting Lists - 52 Week Performance	99.95%	100.00%	2.50

Information on Scoring Methodology

Report Performance Dashboard

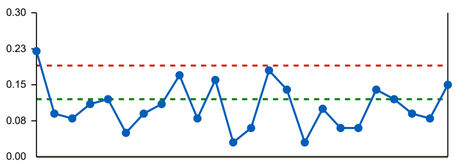
Lincolnshire Community and Hospitals NHS Group

Acute - Quality

Acute - Falls per 1000 bed days resulting in moderate, severe harm & death

United Lincolnshire Teaching Hospitals — Target: 0.19

Activity Volume



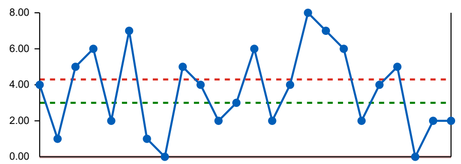
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19

Acute - Pressure Ulcers category 3

United Lincolnshire Teaching Hospitals — Target: 4.30

Activity Volume



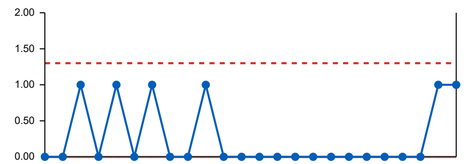
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30

Acute - Pressure Ulcers category 4

United Lincolnshire Teaching Hospitals — Target: 1.30

Activity Volume



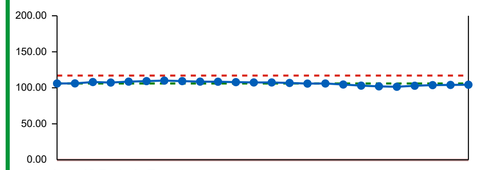
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30

Acute - Summary Hospital Mortality Indicator (SHMI) (rolling year data... 5 month time lag)

United Lincolnshire Teaching Hospitals — Target: 117.00

Activity Volume



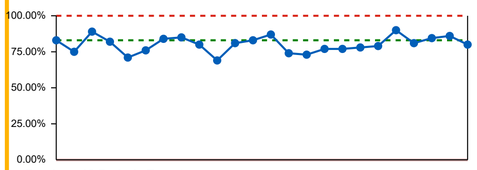
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00	117.00

Acute - Complaints investigated and responded to within agreed timescales

United Lincolnshire Teaching Hospitals — Target: 100.00%

Activity Volume



Previous 12 Periods Targets

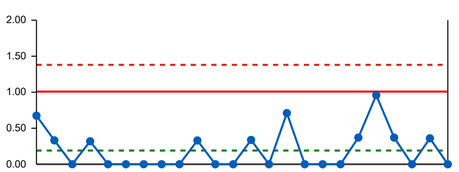
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Community - Quality

Patient Safety - Monthly Injurious Falls per 1000 OBDs

Lincolnshire Community Health Services — Target: 1.38

Activity Volume

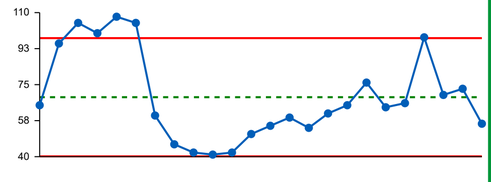


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38

Patient Safety - Pressure Ulcers Category 3

Lincolnshire Community Health Services

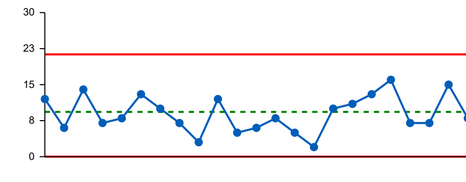


Previous 12 Months Actuals

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
55	59	54	61	65	76	64	66	98	70	73	56

Patient Safety - Pressure Ulcers Category 4

Lincolnshire Community Health Services



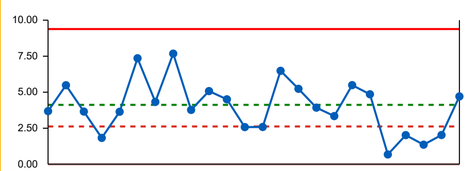
Previous 12 Months Actuals

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
8	5	2	10	11	13	16	7	7	15	8	13

Patient Experience - Complaints - Rate per 1000 WTE

Lincolnshire Community Health Services — Target: 2.62

Activity Volume



Previous 12 Periods Targets

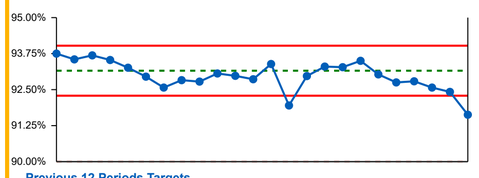
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62	2.62

Acute - Workforce

Acute - Overall percentage of completed mandatory training

United Lincolnshire Teaching Hospitals — Target: 90.00%

Activity Volume



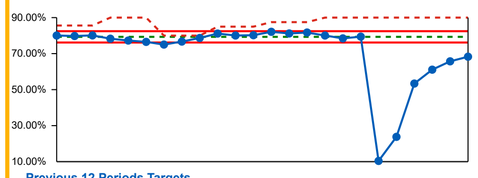
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Acute - Staff Appraisals

United Lincolnshire Teaching Hospitals — Target: 90.00%

Activity Volume



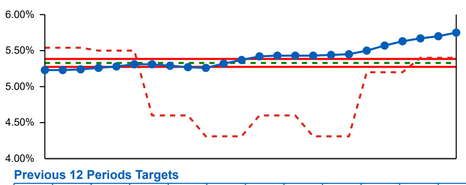
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
87.50%	87.50%	87.50%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Acute - Sickness Absence

United Lincolnshire Teaching Hospitals — Target: 5.40%

Activity Volume



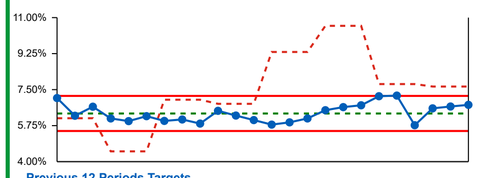
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.60%	4.60%	4.60%	4.31%	4.31%	4.31%	5.20%	5.20%	5.20%	5.40%	5.40%	5.40%

Acute - Number of Vacancies

United Lincolnshire Teaching Hospitals — Target: 7.65%

Activity Volume



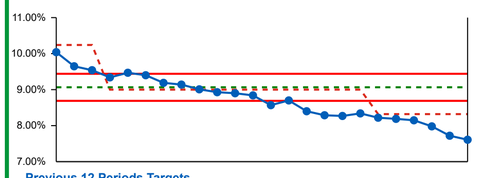
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
9.33%	9.33%	9.33%	10.60%	10.60%	10.60%	7.77%	7.77%	7.77%	7.65%	7.65%	7.65%

Acute - Staff Turnover

United Lincolnshire Teaching Hospitals — Target: 8.32%

Activity Volume



Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	8.32%	8.32%	8.32%	8.32%	8.32%	8.32%

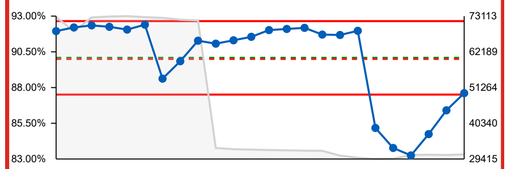
Report Performance Dashboard

Lincolnshire Community and Hospitals NHS Group

Community - Workforce

Workforce - Mandatory Training

Lincolnshire Community Health Services
Activity Volume
Target: 90.00%

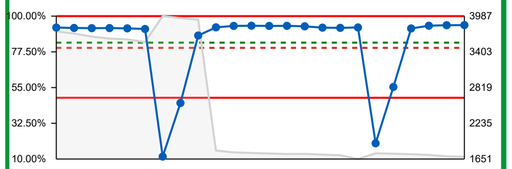


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Workforce - Appraisals

Lincolnshire Community Health Services
Activity Volume
Target: 80.00%

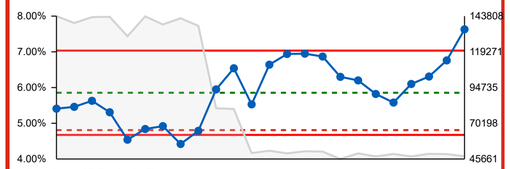


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%

Workforce - Sickness Rate

Lincolnshire Community Health Services
Activity Volume
Target: 4.81%

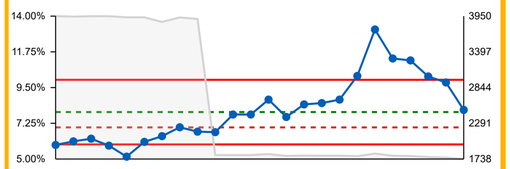


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%	4.81%

Workforce - Vacancy Rate

Lincolnshire Community Health Services
Activity Volume
Target: 6.99%

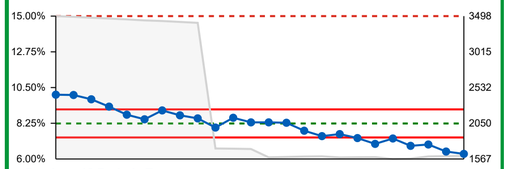


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%	6.99%

Workforce - Turnover

Lincolnshire Community Health Services
Activity Volume
Target: 15.00%



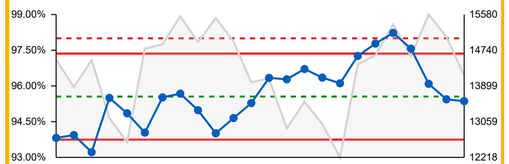
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%	15.00%

Acute - Front Door

UTC - Monthly 4 Hour Performance

Lincolnshire Community Health Services
Activity Volume
Target: 98.00%

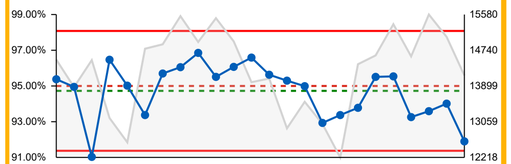


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%

UTC - 15 Minute Triage Compliance - Monthly

Lincolnshire Community Health Services
Activity Volume
Target: 95.00%

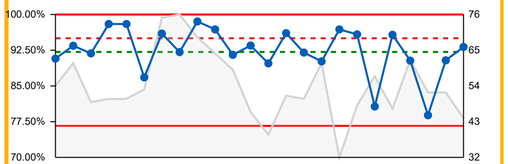


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

UTC - 15 Minute Ambulance Handover

Lincolnshire Community Health Services
Activity Volume
Target: 95.00%

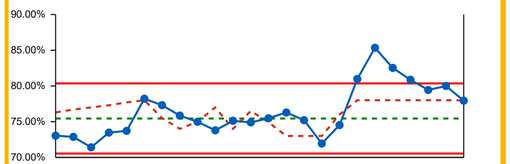


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

ED - 4 hour performance

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 78.00%

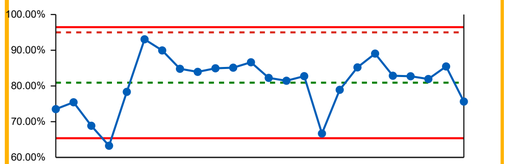


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
74.92%	73.00%	73.00%	73.00%	76.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%	78.00%

ED - % EMAS Conveyance Delayed <45 mins

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 95.00%

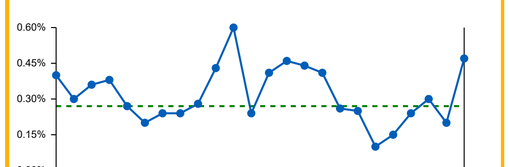


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

ED - % Triage Data Not Recorded

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 0.00%



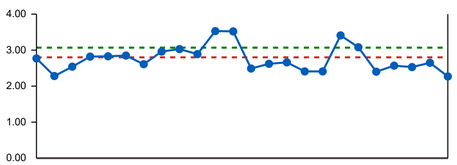
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Acute - Planned

Acute - Hospital Average LoS (Elective)

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 2.80

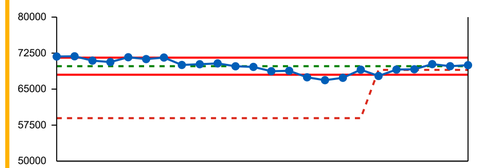


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80

Acute - Waiting List Size

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 69003

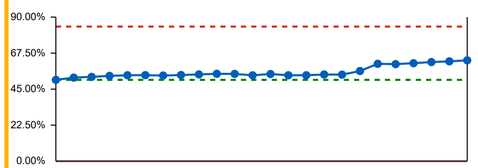


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
58965	58965	58965	58965	58965	69003	69003	69003	69003	69003	69003	

Acute - 18 week incompletes

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 84.10%

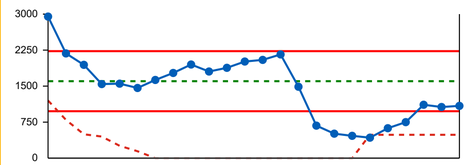


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	84.10%	

Acute - 52 Week Waiters

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 486

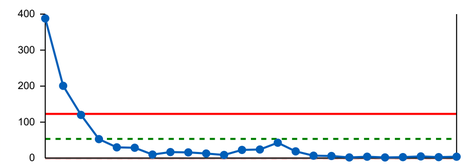


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0	0	0	0	0	486	486	486	486	486	486	

Acute - 65 Week Waiters

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 0

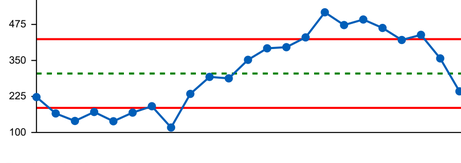


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
0	0	0	0	0	0	0	0	0	0	0	

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 10

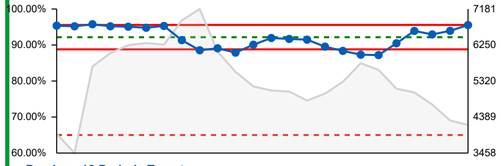


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
10	10	10	10	10	10	10	10	10	10	10	10

Acute - 28 days faster diagnosis

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 80.00%

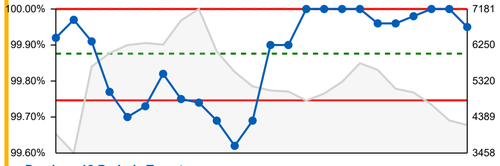


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	80.00%	80.00%	80.00%	80.00%	80.00%	

Cancer - 31-day Treatment (Combined)

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 96.00%



Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	

Cancer - 62-day Treatment (Combined)

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 85.00%

Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	

Acute - Diagnostics achieved

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 99.00%

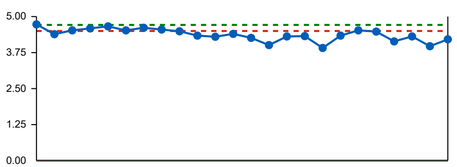
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

Acute - Unplanned

Acute - Average LoS (Non Elective)

United Lincolnshire Teaching Hospitals
Activity Volume
Target: 4.50



Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50

Community - Planned

System Impact - LCHS - LoS Reduction

Lincolnshire Community Health Services

Previous 12 Months Actuals

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
392	396	430	517	473	492	463	421	439	357	243	272

Community Waiting Lists - 18 Week Performance

Lincolnshire Community Health Services
Activity Volume
Target: 65.00%

Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%

Community Waiting Lists - 52 Week Performance

Lincolnshire Community Health Services
Activity Volume
Target: 100.00%

Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

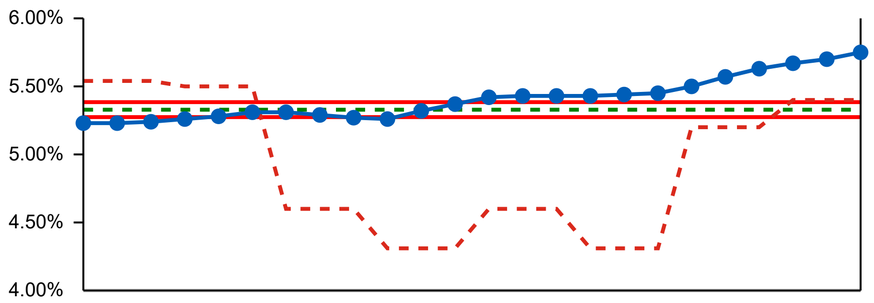
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Sickness Absence

United Lincolnshire Teaching Hospitals
Activity Volume

Target: 5.40%

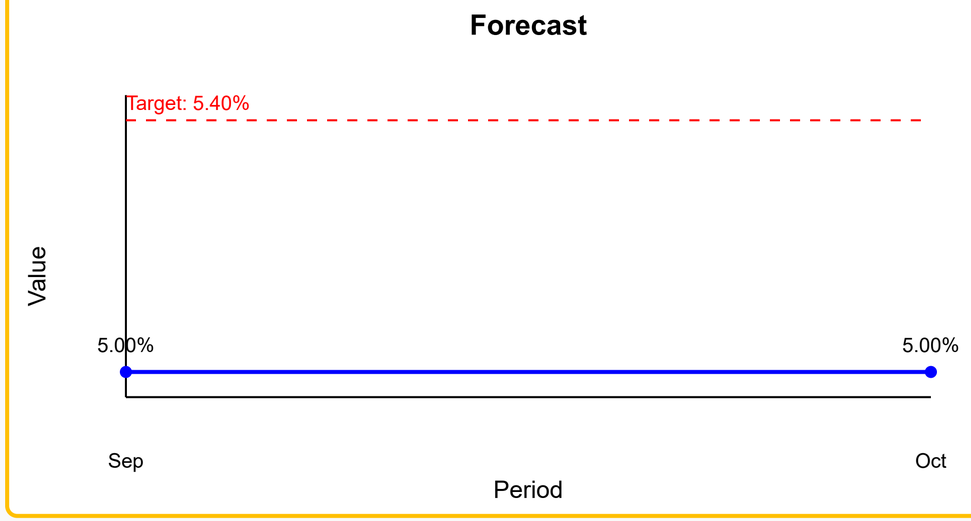


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
4.60%	4.60%	4.60%	4.31%	4.31%	4.31%	5.20%	5.20%	5.20%	5.40%	5.40%	5.40%

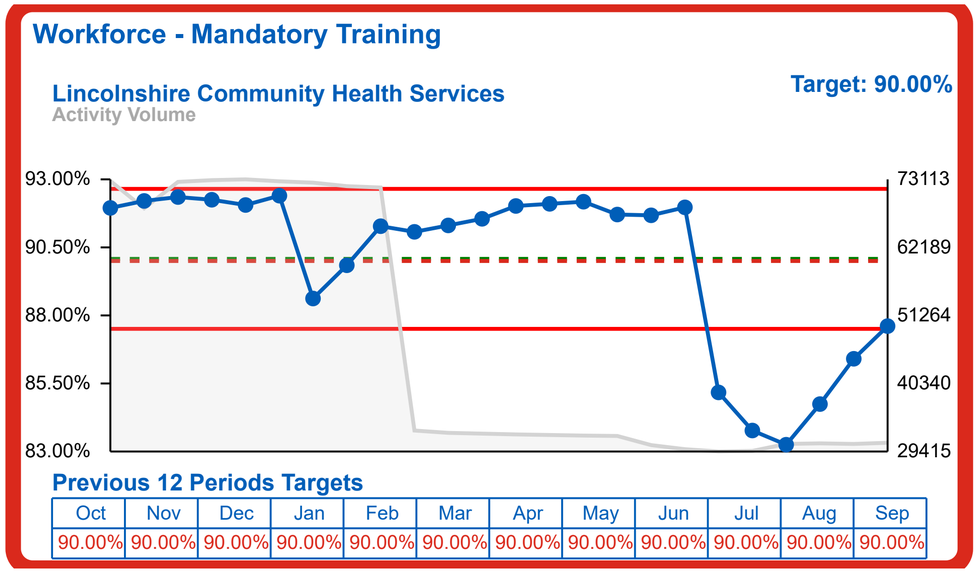
Our September 2026 Sickness Rate is 5.75% against a Q2 Target of 5.70%. Our targets for 2026/27 have been updated using data insights and trend data. Our sickness absence rate is outside of the Q2 Target although within level of tolerance. Reducing long term absence to mitigate impact on services. Absence has seen an increased rate over recent months when compared to the previous year.

There is a continued focus on supporting managers and leaders in absence processes and supporting our people to attend the work environment. Sickness absence multi-disciplinary approach to address both long-term and short-term absences has been launched to support areas of focus. Promotion of the ‘Say Well’ pillar as part of the Work Well plan launch. Deep dives into areas of high absence to understand trends and support with actions and interventions as required in line with policy. Multi-Disciplinary approach to absence reviews has been introduced.



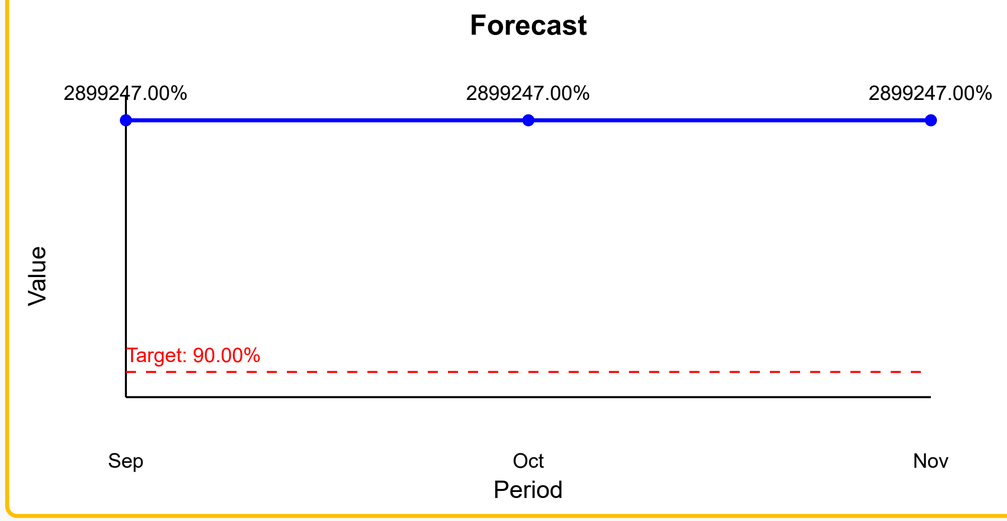
Exception Reporting

Lincolnshire Community and Hospitals NHS Group



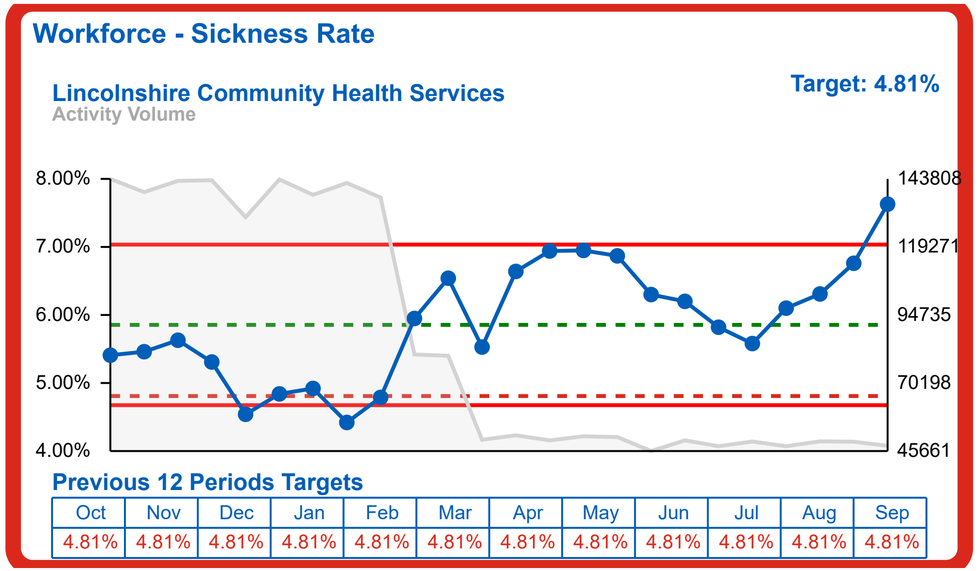
Decrease of 4.65 percentage points across 12 results (1 Oct 2025 to 1 Sep 2026), from 92.23% to 87.61%. Across the latest three months, performance is slightly improving by 4.48%. Access to manual handling, Paediatric Intermediate Life Support and Intermediate life support training continue to be a challenge to improving this metric however there has been an upward trajectory in compliance since June.

Ensuring staff are booked into future dates and contacting non-compliant staff directly. Also to ensure that those on long term sickness and parental leave are properly excluded from the data. Where possible bespoke training for area's is being arranged to help to expedite compliance we expect to see continued improvement over the coming months and if we continue on the current trajectory, we anticipate that we will be over target by Quarter 3



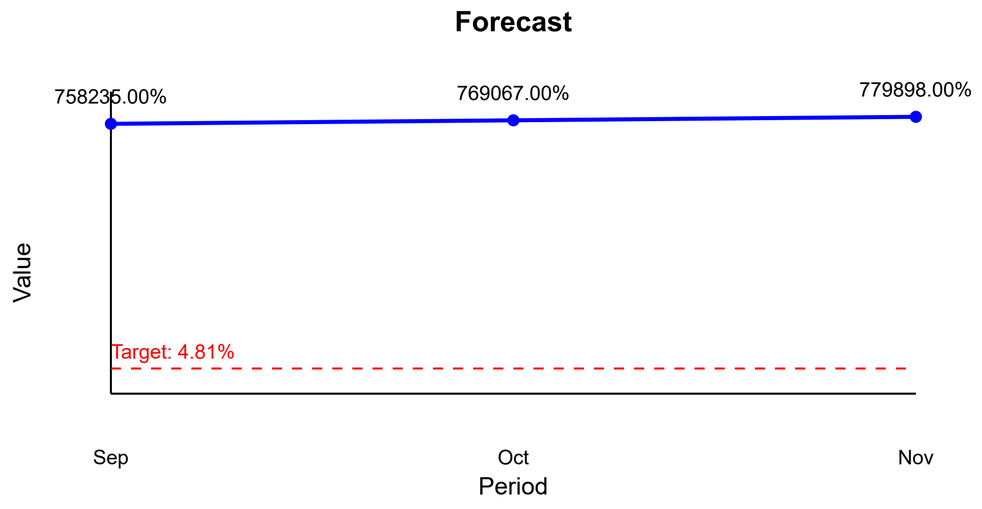
Exception Reporting

Lincolnshire Community and Hospitals NHS Group



Long-term sickness remains a key contributor to the current position, with some cases also subject to ongoing Employee Relations processes and requiring sustained management oversight. The overall top reason for absence continues to be stress, anxiety and depression with 1,568.72 FTE days lost days lost, which is a slight increase from 1,556.32 FTE days lost when compared to the previous month. The second top reason is other musculoskeletal problems (474.23 FTE days lost), followed by gastrointestinal problems (286.46 FTE days lost).

Leaders are now being asked to actively use the 1–28 Day Absence Pathway as the standard framework for managing absence, strengthening early intervention, regular manager contact, timely consideration of reasonable adjustments and proactive planning for a safe return to work. The pathway provides clear management touchpoints at days 1, 3, 7, 14, 21 and 28, with escalation to People Directorate Support and Occupational Health where required. With a more consistent and proactive leadership approach to absence management, future performance is monitored to evidence whether this translates into improved attendance and a reversal of the current deterioration.



Exception Reporting

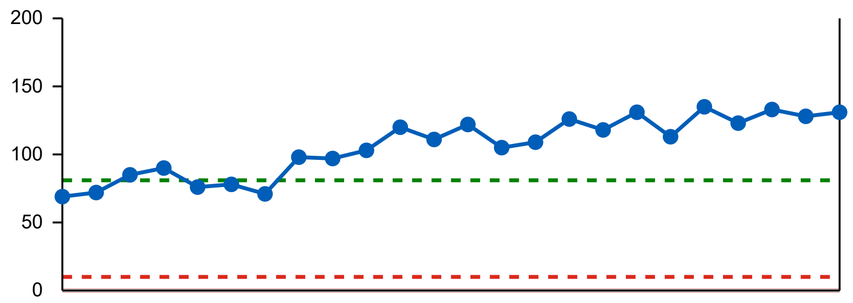
Lincolnshire Community and Hospitals NHS Group

Acute - 104+ Day Waiters

United Lincolnshire Teaching Hospitals

Activity Volume

Target: 10

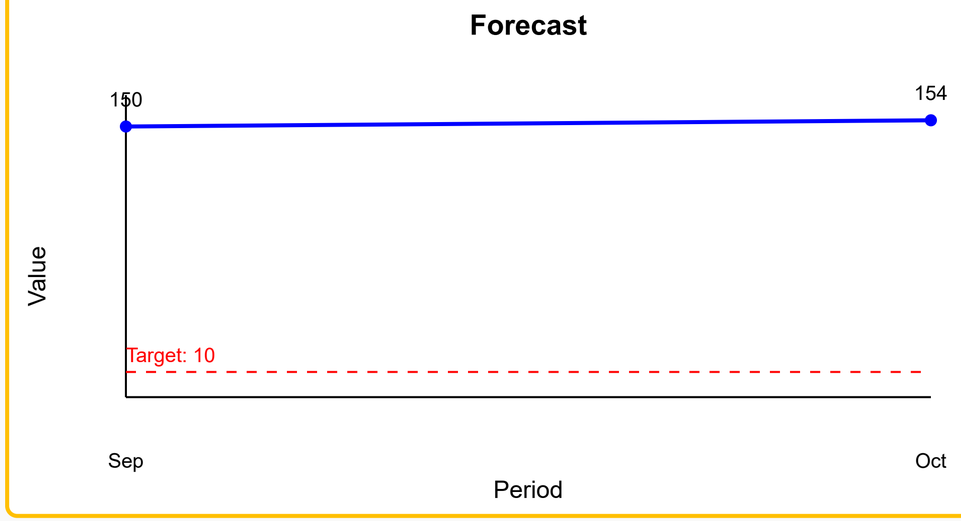


Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
10	10	10	10	10	10	10	10	10	10	10	10

As of 7th October 2026 the 104 Day backlog is at 131 patients. There are 5 main tumour sites of concern: Colorectal 57, Lung 17, Urology 15, Head and Neck 10. 104+ backlog remains above trajectory despite continued reductions. Long waits are concentrated within a small number of tumour sites including Colorectal, Lung, Head & Neck, Urology, Upper GI and Breast. Delays are driven by a combination of diagnostic, outpatient and treatment capacity constraints. A proportion of patients have complex social, mental health or medical needs requiring additional support

Weekly review of all 104+ patients through Cancer Assurance processes. Intensive Support Meetings continue for the highest-risk tumour sites. Individual patient-level recovery plans in place for all patients exceeding 104 days. Enhanced executive oversight through cancer performance governance arrangements. Continued focus on reducing diagnostic delays and improving treatment turnaround times. Longest waiting patients remain the highest operational priority. Dedicated management of vulnerable patients through the Pre-Diagnosis CNS service. Escalation of emerging risks through Care Group and Executive performance meetings. Continued use of additional capacity opportunities to support backlog reduction.



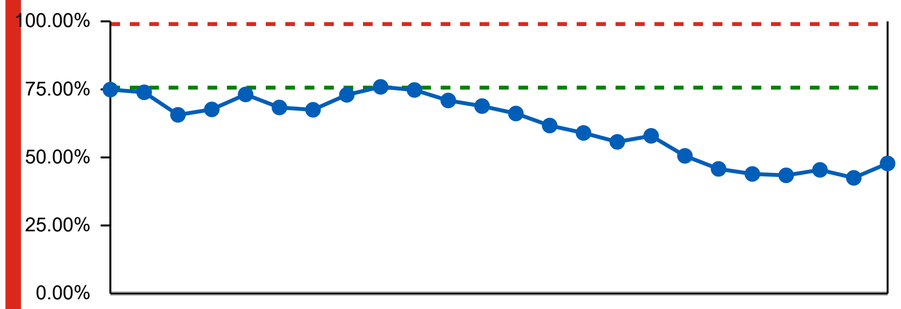
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Acute - Diagnostics achieved

United Lincolnshire Teaching Hospitals
Activity Volume

Target: 99.00%



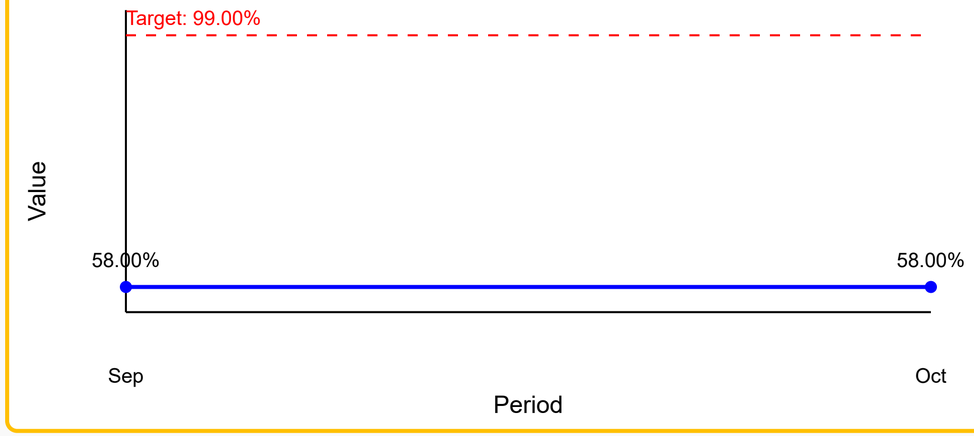
Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

DM01 for Sept was 47.77%, against 99.00% target. Reduction in performance. Most diagnostic breaches sit in. Ultrasound, MRI and cardiac echo. The lack of admin staff is causing booking issues within radiology.

Radiology is working With PSH to look at why such high DNA rates. Cardiology is asking insourcing to increase capacity. Patients are being seen in clinical priority. PSH are now booking the patients.

Forecast



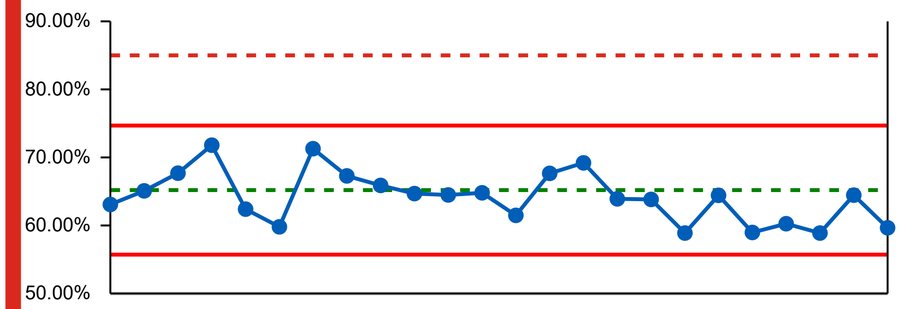
Exception Reporting

Lincolnshire Community and Hospitals NHS Group

Cancer - 62-day Treatment (Combined)

United Lincolnshire Teaching Hospitals
Activity Volume

Target: 85.00%



Previous 12 Periods Targets

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	

Currently at 59.66%, against a target of 85%. Diagnostic, outpatient and treatment capacity pressures continue to impact pathway performance. Surgical capacity remains the most significant constraint affecting achievement of the standard. Increasing pathway complexity and continued patient and medical delays contribute to breaches. A small number of tumour sites account for the majority of long waits and non-compliance.

Intensive Support Meetings remain in place for tumour sites most significantly impacting 62-Day performance. Weekly review of patients approaching Day 62 with focused escalation of delays. Continued optimisation of diagnostic and treatment capacity across services. Recovery plans aligned to reducing 104+ waits and improving pathway compliance. Patients at greatest risk of breach are actively managed through enhanced PTL processes. Pre-Diagnosis CNS support continues for vulnerable patients with complex social or clinical needs. Additional capacity opportunities are utilised where available to reduce pathway delays. Progress monitored through Cancer Performance meetings and Executive oversight arrangements.

No trajectory available

LCHG Scoring

Lincolnshire Community and Hospitals NHS Group

LCHG Score

1. Field Scoring

Each metric is scored based on 3 criteria as per the table below

Score	Target	Trajectory	Plan
0	Above Target	Stable or Improving	Above Plan
0.5	No Target Set	-	No Plan Set
1	Below Target	Deteriorating	Below Plan

2. Total Metric Score

The total score is the sum of the 3 criteria, uplifted to fit a range of 1 - 4

3. Colour Bandings

Range	Colour	Description
1.00 - 2.00	Green	Performing Well/On Track
2.01 - 2.99	Warm Amber	Slightly Below Expectations
3.00	Burnt Orange	Performance Concern
3.01 - 4.00	Red	Underperforming

4. Aggregation

Section scores are calculated based on the average score of all metrics in that section. With the section score being rated using the same logic above

Metric Scoring Example

Lincolnshire Community and Hospitals NHS Group

Metric Name	Value	Target	LCHG Score
Acute - #NOF 48 hrs	29.41%	90.00%	3.50
Acute - #NOF 36 hrs	11.76%		3.00
Acute - eDD issued within 24 hours	91.42%	95.00%	2.50
Acute - Actions from National clinical audits have been or will be completed within agreed timescale	100.00%	100.00%	1.50

Above is an example of 4 metrics with different scores

Acute - #NOF 48 hrs is flagged as red due to the metric being below target and having a deteriorating trajectory

Similarly #NOF 36 hrs is below trajectory but due to the lack of target scores slightly lower but would still be flagged within reporting

Acute - EDD scores 2.5 because whilst the metric is below target, it has a consistent trajectory with no signs of deteriorating

Acute - Actions from clinical audits is flagged as green as the metric is above target and does not have a deteriorating trajectory

NHS
Lincolnshire Community and Hospitals NHS Group

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 November 2026*
Agenda item number	*12.1*
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 Governance Officer*
Author(s)	*Sarah Davy, Group Risk and Datix Manager/ CAS Officer* *Jeremy Daws, Associate Director Compliance and Risk*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Reasonable assurance*
Prior approval process, if applicable	*N/A*
Financial implications, if applicable	*N/A*
Action / decision required	*The Board is asked to:* • *Review the content of the report. There are no further escalations at this time.*

Assurance Rating Key:

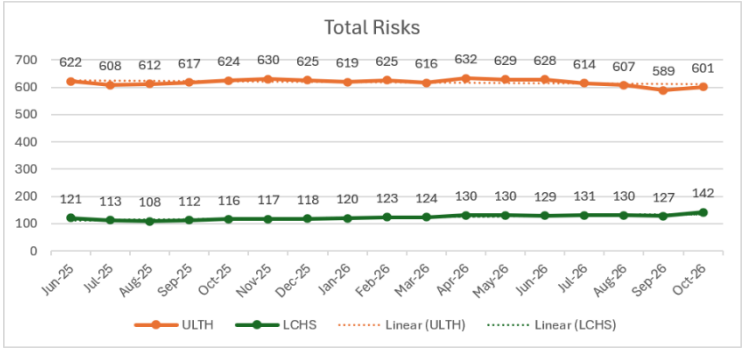
Assurance Rating	***Description***
Green: Substantial Assurance	*Effective controls and appropriate assurances are in place*
Amber: Reasonable Assurance	*Effective controls are mostly in place and actions have been agreed to implement the remaining controls or remedial actions and / or assurances are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

How the report supports the delivery of the LCHG strategic aims & objectives:	
Patients: Better Care – Timely, affordable, high quality care in the right place:	
1a: Improve patient safety, patient experience and deliver clinically effective care	X
1b: Reduce waiting times for our patients	X
1c: Improve productivity and deliver financial sustainability	X
1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda	X
People: Better Opportunities – Develop, empower and retain great people:	X
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	X
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	X
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	X
3c (iii): Enhance our research and innovation capability linked to our population health needs	X
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	X

Executive Summary: Movement over time:

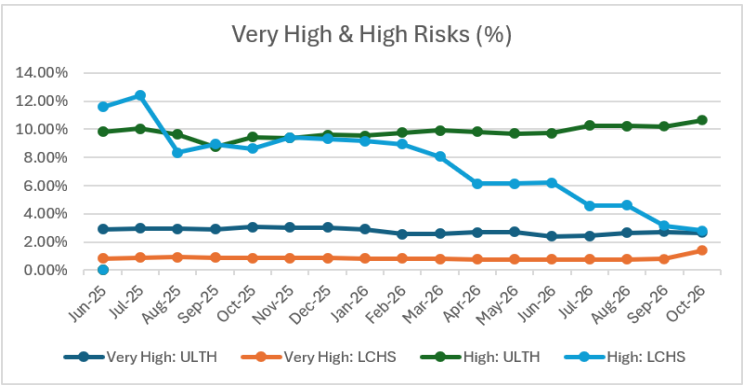
Risk movement over time:

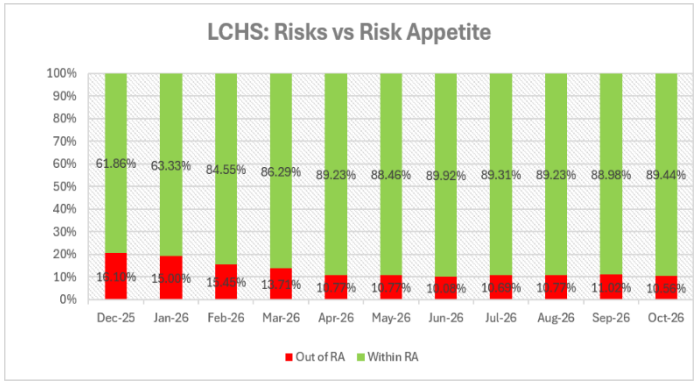
- As of 19 October 2026, there are 743 (LCHS 142 and ULTH 601) risks in total.
- This is an increase of 6 since the last report.
- The chart demonstrates the split between ULTH and LCHS



Very high / High risk movement:

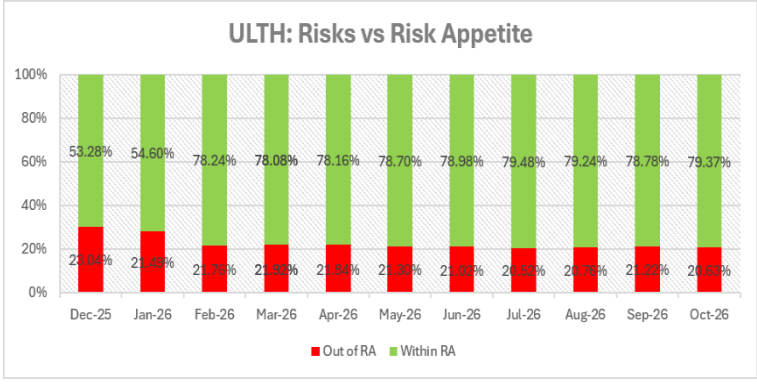
- There are 18 (2%) risks considered to be **very high** (20-25) (see appendix A for full detail)
  - LCHS: 2 (1%)
  - ULTH: 16 (3%)
  - The chart demonstrates an increase of 1 **very high** risk since the previous report
- There are 68 (9%) risks considered to be **high** (15-20) (see appendix B for full detail)
  - LCHS: 4 (3%)
  - ULTH: 64 (11%)
  - The chart demonstrates a decrease of LCHS high risks from 9% in November 2025 to 3% (a decrease of 7 **high** risks).





Risks vs Risk Appetite[1]:

- The proportion of risks reported that **exceed** the risk appetite established for LCHS is lower than ULTH:
  - LCHS: 11%
  - ULTH: 21%



[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 August 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 19 October 2026, there are 743 (LCHS 142 and ULTH 601) risks in total.
- This is **an increase of 6** since the September 2026 report.
- Of the 743 risks, there are 86 (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): 2 (an increase of 1 since previous report):

  Quality Committee (n=1, same as previous report)**:**

  - 849 - Risk of school aged children & young people not receiving speech and language support

  Integration Committee: (n=1; an increase of 1 since previous report):

  - 441 – Board Assurance Framework Over Arching Cyber Risk **** New Risk**

- **ULTH:** Very High (20-25): 16 (same as previous report):

  Quality Committee: (n=7; same as previous report):

  - 4746 - Overdue patients on Ophthalmology PBWL
  - 4855 – Delayed diagnosis of breast cancer
  - 4879 - Recovery of planned care cancer pathways
  - 5016 - Patient flow through Emergency Departments
  - 5101 - Delivery of paediatric epilepsy pathways-across acute and community
  - 5795 – Lack of consultant staffing for Orthodontic service
  - 5800 – Delayed issue of clinic letters due to clinical typing backlog

  People Committee: (n=4; same as previous report):

  - 4844 – Staffing levels requiring an increase in Pharmacy to provide 7-day dispensing service
  - 5093 – Procurement service staffing levels (Pharmacy)
  - 5450 – Risk to Gastro service due to fragility of consultant workforce -
  - 5761 – Risk to IBD service

  Finance and Performance Committee: (n=1; same as previous report):

  - 5020 - Reliance on agency / locum medical staff in Urgent & Emergency Care

Integration Committee: (n=4; same as previous report):

- 4731 – Reliance on paper medical records
- 5563 - Neurology – Service sustainability
- 5711 - Risk to our transformation programme due to changes within the ICB
- 5812 – Board Assurance Framework overarching cyber risk

Risk profile compared to risk appetite:

- **LCHS:** Of the 142 risks, 15 are out of the risk appetite set (an increase of 1 since September 26).
- **ULTH:** Of the 601 risks, 124 are out of the risk appetite set (a decrease of 2 since September 26).

Strategic Objective:	**Defined Risk Appetite[2]:**	**LCHS**		**ULTH**	
		Within	**Out of**	**Within**	**Out of**
1a (i): Improve patient safety	**Cautious:** Prepared to accept risks up to 10	36	11	124	76
1a (ii): Improve patient experience	**Open:** Prepared to accept risks up to 12	6	0	28	5
1a (iii): Deliver clinically effective care	**Open:** Prepared to accept risks up to 12	18	0	23	2
1b: Reduce waiting times for our patients	**Open/Cautious:** Prepared to accept risks rated to 10-12	3	0	21	3
1c: Improve productivity and deliver financial sustainability	**Open:** Prepared to accept risks rated to 12	13	1	65	4
1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda	**Open:** Prepared to accept risks rated to 12	21	1	97	9
2a: Enable our people to fulfil their potential through training, development and education, underpinned by a positive and inclusive culture	**Open:** Prepared to accept risks rated to 12	9	1	19	11
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	**Hungry:** Prepared to accept risks rated as 15/16	3	0	10	3
2c: Nurture compassionate and diverse leadership	**Open:** Prepared to accept risks rated to 12	1	0	7	0
2d: Recognising our people through thanks and celebration	**Hungry:** Prepared to accept risks rated as 15/16	0	0	1	0
3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services	**Open:** Prepared to accept risks rated to 12	5	0	9	9
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

[2] For greater information on the risk appetite agreed by the Group, please refer to **Appendix C.**

3c(i) Enhance our digital capability through innovation delivering the 10 year health plan	**Hungry:** Prepared to accept risks rated as 15/16	4	1	51	1
3c(ii) Enhance our digital capability through delivery of our EPR in 2026/27/28	**Hungry:** Prepared to accept risks rated as 15/16	4	0	21	1
3c(iii) Enhance our research and innovation capability linked to our population health needs	**Hungry:** Prepared to accept risks rated as 15/16	0	0	1	0
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	**Open:** Prepared to accept risks rated to 12	0	0	0	0

1. Purpose

1.1 The purpose of this report is to:

- Enable the Group Board to review the management of significant risks to achievement of strategic objectives and risks
- Review those risks outside of the risk appetite set by Group Board and consider the overall extent of risk exposure within LCHG at this time.

2. Introduction

2.1 The Group's risk registers are recorded on the DatixWeb (LCHS) and DatixIQ (ULTH) Risk Management Systems.

2.2 This report is focussed on, both:

- Significant risks, defined as those with a current rating of Very High, scoring 20-25;
- Risks outside of the risk appetite set previously by the Group Board.

Both elements are mapped against the Group's strategic objectives and are further aligned to the lead sub-committees.

NB: Full details of all 'Very High' and 'High', scoring 15-25, risks please see **Appendix A (LCHS) and Appendix B (ULTH).**

2.3 The LCHG Risk Register Confirm and Challenge Group continues to meet monthly, reviewing all High and Very High risks, as well as receiving presentations from clinical and corporate areas on a rotational basis to enable constructive feedback to be provided.

3. Group Risk Profile:

3.1: Lincolnshire Community Health Services NHS Trust

Risk profile: This month compared to last report:

This month vs. last month	Number of risks	Very low (1-3)	Low (4-6)	Moderate (8-12)	High (15-16)	Very high (20-25)
Oct – 2026	142	**4** (3%)	**44** (31%)	**88** (62%)	**4** (3%)	**2** (1%)
Aug – 2026	130	**3** (2%)	**45** (35%)	**75** (57%)	**6** (5%)	**1** (1%)

- The number of risks has increased by 12 compared to the previous report.
- 2 risks are scored as 'Very High'. There is an increase of 1from the previous report.
- 4 risks are scored as 'High'. This is a decrease of 2 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	1	0	1	0	2
	Quite likely (4) 71-90% chance	1	4	13	4	1	23
	Reasonably likely (3) 31-70% chance	2	4	23	18	0	47
	Quite unlikely (2) 10-30% chance	0	7	28	24	4	63
	Extremely unlikely (1) <10% chance	0	1	2	3	1	7
	Total	3	17	66	50	6	142

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)
Oct – 2026	601	**42** (7%)	**153** (25%)	**326** (54%)	**64** (11%)	**16** (3%)
Aug – 2026	607	**43** (7%)	**145** (24%)	**341** (56%)	**62** (10%)	**16** (3%)

- The number of risks has decreased by 6 compared to the previous report.
- 16 risks are scored as 'Very High'. This remains the same as the previous report.
- 64 risks are scored as 'High'. This is an increase of 2 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	13	15	14	0	42
	Quite likely (4) 71-90% chance	2	23	68	45	2	140
	Reasonably likely (3) 31-70% chance	2	37	98	75	4	216
	Quite unlikely (2) 10-30% chance	18	28	65	40	9	160
	Extremely unlikely (1) <10% chance	8	6	8	15	6	43
	Total	30	107	254	189	21	601

4. Risks by Strategic Objective:

4.1: Strategic objective 1a (i) Patient Safety

The Group's Risk Appetite is described as: 'Cautious' (accept risks up to 10)

Lincolnshire Community Health Services NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	Cautious Accept up to 10	36 (77%)	11 (23%)
		47	
Aug – 2026		36 (78%)	10 (22%)
		46	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	0 (0%)	1 (100%)
2	1 (50%)	1 (50%)

- 77% of LCHS risks (36) 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
Oct – 2026	Cautious Accept up to 10	124 (62%)	76 (38%)
		200	
Aug – 2026		129 (62%)	79 (38%)
		208	

Number of risks 15-25	High (15-16)	Very high (20-25)
27	20 (77%)	7 (23%)
26	20 (77%)	6 (23%)

- 62% of ULTH risks (124) are within the 'Cautious' risk appetite.
- There are 7 'Very High' risks.

Risks outside of the Risk Appetite: LCHS: n=11 / ULTH: n=76

Summary of the 'Very High' risks (n=8):

LCHS: (n=1):

ID	Title	Risk level (current)	Care Group	Date of latest review
849	Risk of School-Aged Children and Young People Not Receiving Timely Speech and Language Therapy Support	Very high risk (20-25)	Family Health	25/09/2026

ULTH (n=7)

ID	Title	Risk level (current)	Care Group	Date of latest review
4746	Overdue patients on Ophthalmology PBWL	Very high risk (20-25)	Surgery	29/09/2026
4855	Delayed diagnosis of breast cancer	Very high risk (20-25)	Family Health	28/09/2026
4879	Recovery of planned care cancer pathways	Very high risk (20-25)	Corporate	30/09/2026
5016	Patient Flow Through Emergency Departments.	Very high risk (20-25)	Medicine	21/10/2026
5101	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	Very high risk (20-25)	Family Health	28/09/2026
5800	Delayed issue of clinic letters due to clinical typing backlog	Very high risk (20-25)	Corporate	13/10/2026
5795	Lack of Consultant staffing for Orthodontic service	Very high risk (20-25)	Surgery	29/09/2026

4.2: Strategic objective 1a (ii) Patient Experience

The Group's Risk Appetite is described as: 'Open' (accept risks up to 12)

Lincolnshire Community Health Services NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	**Open** Accept up to 12	6 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		6				
Aug – 2026		6 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		6				

- 100% of LCHS risks (6) are within the 'Open' risk appetite.
- There are no 'Very High' risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	**Open** Accept up to 12	28 (85%)	5 (15%)	5	5 (100%)	0 (0%)
		33				
Aug – 2026		34 (92%)	3 (8%)	3	3 (100%)	0 (0%)
		37				

- 85% of ULTH risks (28) are within the 'Open' risk appetite.
- There are no 'Very High' risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=5

Summary of the 'Very High' risks (n=0):

- There are none.

4.3: Strategic objective 1a (iii) Clinically Effective Care

The Group's Risk Appetite is described as: 'Open' (accept risks up to 12).

Lincolnshire Community Health Services NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	**Open** Accept up to 12	18 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		18				
Aug – 2026		13 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		13				

- 100% of LCHS risks (18) are within the 'Open' risk appetite.
- There are no 'Very High' risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	**Open** Accept up to 12	23 (92%)	2 (8%)	2	2 (100%)	0 (0%)
		25				
Aug – 2026		19 (90%)	2 (10%)	2	1 (50%)	1 (50%)
		21				

- 92% of ULTH risks (23) are within the 'Open' risk appetite.
- There are no 'Very High' risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=2

Summary of the 'Very High' risks (n=0):

- There are none.

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
Oct – 2026	**Open/ Cautious** Accept up to 12	3 (100%)	0 (0%)
		3	
Aug – 2026		4 (100%)	0 (0%)
		4	

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 (3) are within the 'Open/Cautious' risk appetite
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	**Open/ Cautious** Accept up to 12	21 (88%)	3 (12%)
		24	
Aug – 2026		20 (91%)	2 (9%)
		22	

Number of risks 15-25	High (15-16)	Very high (20-25)
3	3 (100%)	0 (0%)
2	2 (100%)	0 (0%)

- 88% of ULTH risks (21) are within the 'Open/Cautious' risk appetite.
- There are no 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=3

Summary of the 'Very High' risks (n=0):

- There are none.

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
Oct – 2026	**Open** Accept risks up to12	13 (93%)	1 (7%)
		14	
Aug – 2026		14 (93%)	1 (7%)
		15	

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 no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	**Open** Accept risks up to12	65 (94%)	4 (6%)
		69	
Aug – 2026		65 (94%)	4 (6%)
		69	

Number of risks 15-25	High (15-16)	Very high (20-25)
4	3 (75%)	1 (25%)
4	3 (75%)	1 (25%)

- 94% of ULTH risks (65) are within the 'Open' risk appetite
- There is 1 'Very High' ULTH risk.

Risks outside of the Risk Appetite: LCHS: n=1 / ULTH: n=4

Summary of the 'Very High' risks (n=1):

Trust:	Risk ID	Risk Title	Risk score	Care Group	Date of latest review:
ULTH	5020	Reliance on agency / locum medical staff in Urgent & Emergency Care	Very high risk (20)	Medicine	16/09/2026

4.6: Strategic objective 1d - Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda

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
Oct – 2026	**OPEN** Accept up to 12	21 (95%)	1 (5%)
		22	
Aug – 2026		18 (90%)	2 (10%)
		20	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	1 (100%)	0 (0%)
2	2 (100%)	0 (0%)

- 95% of LCHS risks (21) are within the 'Open' risk appetite
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	**OPEN** Accept up to 12	97 (92%)	9 (8%)
		106	
Aug – 2026		95 (89%)	12 (11%)
		107	

Number of risks 15-25	High (15-16)	Very high (20-25)
9	9 (100%)	0 (0%)
12	12 (100%)	0 (0%)

- 92% of ULTH risks (97) are within the 'Open' risk appetite
- There are no 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=1 / ULTH: n=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 high quality training, development and education, underpinned by a positive and inclusive culture

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
Oct – 2026	**OPEN** Accept up to 12	9 (90%)	1 (10%)
		10	
Aug – 2026		5 (80%)	1 (20%)
		5	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	1 (100%)	0 (0%)
1	1 (100%)	0 (0%)

- 90% of LCHS risks (9) are within the 'Open' risk appetite.
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	**Open** Accept up to 12	19 (63%)	11 (37%)
		30	
Aug – 2026		15 (63%)	10 (37%)
		24	

Number of risks 15-25	High (15-16)	Very high (20-25)
11	10 (91%)	1 (9%)
10	9 (100%)	1 (0%)

- 63% of ULTH risks (19) are within the 'Open' risk appetite.
- There is 1 'Very High' ULTH risk.

Risks outside of the Risk Appetite: LCHS: n=1 / ULTH: n=11

Summary of the 'Very High' risks (n=1):

Trust:	Risk ID	Risk Title	Risk score	Care Group	Date of latest review:
ULTH	5450	Risk to Gastro service due to fragility of consultant workforce	Very high risk (20)	Group Chief Operating Officer	10/09/2026

4.8: Strategic objective 2b - Create a culture that empowers our people to deliver change through continuous improvement and innovation

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)
Oct – 2026	Hungry Accept risks of 15/16	3 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		3				
Aug – 2026		3 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		3				

- 100% of LCHS risks (3) are within the risk appetite established.
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	Hungry Accept risks of 15/16	10 (77%)	3 (23%)	5	2 (40%)	3 (60%)
		13				
Aug – 2026		11 (79%)	3 (21%)	5	2 (40%)	3 (60%)
		14				

- 77% of ULTH risks (10) are within the 'Hungry' risk appetite.
- There are 3 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=3

Summary of the 'Very High' risks (n=3):

ULTH:

Trust:	Risk ID	Risk Title	Risk score	Care Group	Date of latest review:
ULTH	4844	Risk of patient harm from restricted Pharmacy cover and workforce shortfalls (including seven-day service)	Very high risk (20)	Group Chief Medical Officer - Pharmacy	14/08/2026
ULTH	5093	Risk to medicines availability and financial sustainability due to Pharmacy support staff vacancies	Very high risk (20)	Group Chief Medical Officer - Pharmacy	29/09/2026
ULTH	5761	Risk of Patient Harm and Deteriorating IBD Outcomes Due to Insufficient IBD Clinical Nurse Specialist Workforce Capacity	Very high risk (20)	Medicine	21/10/2026

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	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	OPEN Accept up to 12	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				
Aug – 2026		1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				

- 100% of LCHS risks (1) are within the risk appetite established.
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	OPEN Accept up to 12	7 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		7				
Aug – 2026		8 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		8				

- 100% ULTH risks (7) are within the risk appetite established.
- There are no 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=0

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)
Oct – 2026	Hungry Accept risks of 15/16	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Aug – 2026		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- There are no LCHS risks aligned to Strategic Objective 2d.

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)
Oct – 2026	Hungry Accept risks of 15/16	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				
Aug – 2026		1 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		1				

- 100% of ULTH risks (1) are within the risk appetite established.
- There are no 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=0

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)
Oct – 2026	**OPEN** Accept up to 12	5 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		5				
Aug – 2026		5 (100%)	0 (0%)	0	0 (0%)	0 (0%)
		5				

- 100% of LCHS risks (5) are within the risk appetite established.
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite	Number of risks 15-25	High (15-16)	Very high (20-25)
Oct – 2026	**Open** Accept up to 12	9 (50%)	9 (50%)	9	7 (67%)	2 (33%)
		18				
Aug – 2026		11 (58%)	8 (42%)	9	6 (67%)	3 (33%)
		19				

- 50% of ULTH risks (9) are within the 'Open' risk appetite.
- There are 2 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=9

Summary of the 'Very High' risks (n=2):

ULTH:

Trust:	Risk ID	Risk Title	Risk score	Care Group	Date of latest review:
ULTH	5563	Neurology – Service sustainability	Very high risk (20)	Medicine	23/09/2026
ULTH	5711	Risk to our transformation programme due to changes within the ICB	Very high risk (20)	Corporate	06/10/2026

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
Oct – 2026	**Hungry** Accept risks up to15/16	4 (100%)	0 (0%)
		4	
Aug – 2026		4 (100%)	0 (0%)
		4	

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 (4) are within the risk appetite established.
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	**Hungry** Accept risks up to 15/16	0 (0%)	0 (0%)
		0	
Aug – 2026		0 (0%)	0 (0%)
		0	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- There are no ULTH risks aligned to this objective.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=0

Summary of the 'Very High' risks (n=0):

- There are none.

4.13: Strategic objective 3c(i) - Enhance our digital capability through innovation delivering the 10-year health plan

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
Oct – 2026	HUNGRY Accept up to 15/16	4 (80%)	1 (20%)
		5	
Aug – 2026		5 (100%)	0 (0%)
		5	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	0 (0%)	1 (100%)
0	0 (0%)	0 (0%)

- 80% of LCHS risks (4) are within the risk appetite established.
- There is 1 'Very 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
Oct – 2026	HUNGRY Accept up to 15/16	51 (98%)	1 (2%)
		52	
Aug – 2026		53 (98%)	1 (2%)
		54	

Number of risks 15-25	High (15-16)	Very high (20-25)
3	2 (67%)	1 (33%)
3	2 (67%)	1 (33%)

- 98% of ULTH risks (51) are within the 'Hungry' risk appetite.
- There is 1 'Very High' ULTH risk.

Summary of risks outside of the Risk Appetite: LCHS: n=1 / ULTH: n=1

Summary of the 'Very High' risks (n=2):

Trust:	Risk ID	Risk Title	Risk score	Division	Date of latest review:
LCHS	441	Board Assurance Framework overarching Cyber risk	Very high risk (20)	Corporate – Digital Services	18/09/2026
ULTH	5812	Board Assurance Framework overarching Cyber risk	Very high risk (20)	Corporate	20/10/2026

5.4: Strategic objective 3c(ii)- Enhance our digital capability through delivery of our EPR in 2026/27/28

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
Oct – 2026	**HUNGRY** Accept up to 15/16	4 (100%)	0 (0%)
		4	
Aug – 2026		4 (100%)	0 (0%)
		4	

Number of risks 15-25	High (15-16)	Very high (20-25)
1	1 (100%)	0 (0%)
1	1 (100%)	0 (0%)

- 100% of LCHS risks (4) are within the risk appetite established.
- There are no 'Very High' LCHS risks.

United Lincolnshire Teaching Hospitals NHS Trust

Risk appetite and number of risks rated as 'High' or 'Very High':

This month vs. last month	Risk Appetite	Within Risk Appetite	Outside of Risk Appetite
Oct – 2026	**HUNGRY** Accept up to 15/16	21 (95%)	1 (5%)
		22	
Aug – 2026		23 (96%)	1 (4%)
		24	

Number of risks 15-25	High (15-16)	Very high (20-25)
2	1 (50%)	1 (50%)
2	1 (50%)	1 (50%)

- 95% of ULTH risks (21) are within the 'Hungry' risk appetite.
- There is 1 'Very High' ULTH risk.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=1

Summary of the 'Very High' risks (n=1):

Trust:	Risk ID	Risk Title	Risk score	Care Group	Date of latest review:
ULTH	4731	Reliance on paper medical records	Very high risk (20)	Corporate – Digital Services	19/10/2026

5.4: Strategic objective 3c(iii)- Enhance our research and innovation capability linked to our population health needs
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
Oct – 2026	**HUNGRY** Accept up to 15/16	0 (0%)	0 (0%)
		0	
Aug – 2026		0 (0%)	0 (0%)
		0	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- There are no LCHS risks aligned to strategic objective 3c (iii).

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
Oct – 2026	**HUNGRY** Accept up to 15/16	1 (100%)	0 (0%)
		1	
Aug – 2026		1 (100%)	0 (0%)
		1	

Number of risks 15-25	High (15-16)	Very high (20-25)
0	0 (0%)	0 (0%)
0	0 (0%)	0 (0%)

- 100% of ULTH risks (1) are within the 'Hungry' risk appetite.
- There are no 'Very High' ULTH risks.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=0

Summary of the 'Very High' risks (n=0):

- There are none.

4.14: Strategic objective 3d - Deliver aligned approach in collaboration with our partners to deliver efficient outcomes and avoid duplication of care.

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)
Oct – 2026	**OPEN** Accept up to 12	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Aug – 2026		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- There are no LCHS risks aligned to strategic objective 3d.

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)
Oct – 2026	**OPEN** Accept up to 12	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				
Aug – 2026		0 (0%)	0 (0%)	0	0 (0%)	0 (0%)
		0				

- There are no ULTH risks aligned to strategic objective 3d.

Risks outside of the Risk Appetite: LCHS: n=0 / ULTH: n=0

Summary of the 'Very High' risks (n=0):

- There are none.

Appendices

- Appendix A – LCHS Very High and High Risks November 2026.
- Appendix B – ULTH Very High and High Risks November 2026.
- Appendix C – Further detail of the risk appetite agreed by the Group.

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Accountable to	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	Risk Title	What is the risk?	Controls in place	How is the risk measured?	Risk Reduction Plan	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk Appetite	Risk level (acceptable)	Review date
Strategic Objective									**1a (i) Improve patient safety**																	
849		Physical or Psychological Harm	Group Chief Operating Officer	Farbrace, Kylie	Keeling, Kerry-Jane	Children's & Young Person's (CYP) Group		03/03/2026	20	Planned Care Group	Children & Young People CBU	Children's SaLT (Speech and Language Therapy)		Risk of School-Aged Children and Young People Not Receiving Timely Speech and Language Therapy Support	As a result of an increase in demand nationally & regionally for SLT support there is a risk that school aged children & young people will not receive the speech and language support they require to meet their social, emotional, educational, and health needs in an appropriate timeframe for their development, resulting in poor cognitive & social outcomes increasing lifelong health inequalities.	1. Advice and activities are given the patient's family and/or educational setting, ensuring they are safe to wait. 2. An appropriate skill mix is used, for example assessments are carried out by SLT and most therapy blocks completed by SLTAs. 3. Mix of face to face and virtual sessions 4. Increased the referral acceptance criteria: focused on highly complex patients only	-Waiting Time breaches -EHCP requirements -Complaints received	Action 1. Recognising that the service has exhausted internal controls to reduce the risk, the service will work with the Local Authority, ICB and Schools within Lincolnshire to review commissioning arrangements and deployment of resources across the System to develop a system proposal for changes to support improved outcomes for CYP with Speech Language and Communication Needs. Lead: Kerry-Jane Keeling Completion date: August 2026 Action 2. Following the development of a system led proposal for commissioning and joint working arrangements across the system. Seek agreement and/or funding for proposed changes. Lead: Kerry-Jane Keeling Completion date: March 2027 Action 3. Adjust working practises and/or workforce to new system model Lead: Katie ClementsCompletion date:	25/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very High Risk (20-25)	20	Above Risk Appetite	8	23/10/2026
Strategic Objective									**1c: Improve productivity and deliver financial sustainability**																	

860		Finances	Group Chief Finance Officer	Antunes Goncalves, Paul	Phoenix, Kat			26/05/2026	20	Corporate	Finance and Performance			Risk of failure to deliver the LCHS CIP target in full for 2026-27	As a result of possible delays in planned schemes, the potential non-viability of identified opportunities at the required pace, the complexity of implementing savings plans during a period of significant organisational transformation, and the reliance on cross-organisational delivery of the CIP aligned to the "Acute to Community" strategy, there is a risk that the Trust may not deliver the £8.9m efficiency requirement set out in the LCHS financial plan, which would lead to reduced financial sustainability, potential failure to meet statutory financial duties, reputational damage for the Trust, a reduced NOF rating, and an increased risk of imbalance across the Group where one organisation overdelivers and another underdelivers against statutory requirements.	1. National policy: - NHS annual budget setting and monitoring processes - Breakeven Plan - NHS monitoring status and development of schemes. - Acute to Community, Analogue to digital. 2. LCHS policy: - Detailed Financial plan inclusive of the headcount reductions has been submitted and ownership is in place for delivery. - 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. 3. LCHS governance: - Detailed CIP reporting via PMO software (Monday.com) supported by QIA process at Productivity, Improvement, Transformation Oversight Forum (PITOF)	1. The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE. 2. For 2026/27 the Trust continues to be monitored weekly on the status of the CIP programmes and their level of maturity. 3. The Trust monitors internally against its CIP targets inclusive of specific Care Group and Transformational scheme targets through the PRM's, GLT and PITOF. 4. Scrutiny & oversight is increased as all committees now meet as a group and allows confirm & challenge across the group. 5. Monthly Reports into Integration Committee and Finance Committee.	Action 1. Working with Corporate and Operational colleagues to clearly identify CIP schemes. Completion date: 30th June 2026 Action 2. Increased CIP governance & monitoring arrangements through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups as required) weekly reports into ELT and introduction of Monday.com. Completion date: 31st March 2027 Action 3. Alignment with the Group Strategy for Acute to Community, Digital to Analogue. Completion date: 31st March 2027 Action 4. Continued focus on exploration of new opportunities and development of future programme of cost improvement. Completion date: 31st March 2027 Action 5. SRO's assigned to identified CIP opportunities – ratification process taking place. Completion date: 31st May 2026	24/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Above Risk Appetite	9	24/12/2026
Strategic Objective								**1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda**																			
799		Regulatory Compliance	Group Chief Estates & Facilities	Davey, Keiron	Davey, Keiron	Health and Safety Committee	Fire Safety Group	04/07/2025	25	Corporate	Estates & Facilities	Fire		Potential for a Major Fire	If a fire occurs in one of the Trust's work locations and is not contained due to issues with fire/smoke detection/alarm systems; compartmentation/containment or emergency lighting it may develop into a major fire resulting in physical and psychological harm, and extensive property damage with subsequent long term consequences for the continuity of services.	Trust Fire Safety policy National Guidance including HTM, HBN, British standards, ACOP Trust Protocols and Policies Fire Safety Training including managerial role. compliance rates Fire wardens Fire drills Governance committees, FEG, FSG, HS Committee FPC. Annual Fire Safety declaration including PEEP awareness reporting of unwanted Fire alarm activations reports of Fire Regulator from audits conducted Fire risk Assessments			13/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Above Risk Appetite	10	13/11/2026
Strategic Objective								**2a: Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture**																			

681		Regulatory Compliance	Group Chief Integration Officer	Farbrace, Kylie	Keeling, Kerry-Jane	Children's & Young Person's (CYP) Group		05/02/2024	20	Planned Care Group	Children & Young People CBU	Children in Care		Children in Care - unable to meet IHA and RHA timescales	As a result of insufficient capacity within the Children in Care Service and an outdated budget that has not been reviewed for several years, there is a risk that the service will be unable to meet statutory timescales for Initial Health Assessments (IHAs) and Review Health Assessments (RHAs) for children in care, given the significant increase in demand resulting in delays in identifying and addressing health needs, reduced access to necessary care, negative impact on service user and carer experience, and reputational damage to the service.	The number of children under the care of Lincolnshire County Council continues to grow year on year increasing the demand for IHA and RHA assessments. The service has only been able to offer the amount of IHA appointments needed to meet this demand at significant cost pressure to LCHS. LCHS are unable to continue to cover this additional financial support needed from 01.04.24. An options appraisal has been completed to identify the increase in funding to meet the increased demand for IHA and RHAs, this is attached to the record.	Measured by monitoring the percentage of CYP receiving IHAs and RHAs within statutory timescales.	1) Recruitment of dedicated medical time, via community paediatrics 2) Work with Local Authority and ULTH to bring CiC service and Adoption/Fostering medicals together operationally to maximise efficiency and improve recruitment opportunities 3) Seek commissioning review from ICB.	23/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Above Risk Appetite	3	16/10/2026
Strategic Objective								**3c (i) Enhance our digital capability through innovation delivering the 10 year health plan**																				
441		Service Disruption	Group Chief Integration Officer	Pryke-Walker, Mr Jimmy	Pryke-Walker, Mr Jimmy	Digital Oversight Group		23/11/2018	25	Corporate	Digital Services (ICT)	Digital Health		Board Assurance Framework Over Arching Cyber Risk	As a result of failure in preventing a successful cyber-attack, there is risk that a successful event is likely to cause detrimental impact to the delivery of care and related corporate services, resulting in patient harm, operational disruption, data loss, financial implications, and reputational damage for the Trust and partners in the Lincolnshire ICS.	Please refer to the list of identified risk as detailed in the Risk statement section. Each risk will have updates associated with any gaps in cyber or information security base line controls which for ULTH and Lincs ICS partner are aligned with the DSPT CAF standards.	Measured through a combination of cyber control KPIs and empirical evidence such as actual breaches and identified impacts suffered by other organisations of similar and greater size. Additionally, regular threat intelligence updates indicate new vulnerability, how exposure is exploited, and what associated threat actor appetite is driving the focus e.g. on the healthcare sector.	Action 1. Appoint a named executive to own and coordinate cyber risk Lead: BoardCompletion date: by next RC&C meeting Action 2. Create and maintain a dedicated cyber risk on the Board Assurance Framework Lead: Risk PartnerCompletion date: Next RC&C meeting Action 3. Agree a cyber risk appetite and operational tolerances, Lead: BoardCompletion date: by next RC&C meeting Action 4. Understand the organisation's cyber risk and what it means in practice with respect to the impact on essential functions (critical clinical, operational, digital and supplier-provided services). Lead: CIO Completion date: 01 Sep 2026 Action 5. Identify the systems and services most critical to safe care and continuity and agree recovery priorities. Lead: Chris BaileyCompletion	18/09/2026	Quite likely (4) 71-90% chance	Extreme (5)	Very High Risk (20-25)	20	Above Risk Appetite	15	03/12/2026
Strategic Objective								**3c (ii) Enhance our digital capability through delivery of our EPR in 2026/27/28**																				

815		Regulatory Compliance	Group Chief Integration Officer	Pryke-Walker, Mr Jimmy	Scott, Ian	Digital Oversight Group	Digital Clinical Safety Group	14/10/2025	20	Corporate	Digital Services (ICT)	Digital Health		Failure to Meet Digital Clinical Safety Standards	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 review before formal approval at Digital Oversight Group	Clinical Risk Management System (CRMS) monitoring and reporting	Key action is to integrate ULTH Clinical Safety policy & process across LCHS as a Group (LCHG) policy & process as agreed with Group CNIO. This is dependent on ULTH resource and capacity. In the interim Ian Scott (LCHS CCDIO) will develop LCHS Clinical Safety knowledge and awareness, review new changes to systems, advise on programmes of work and draft CSCRs as able with Digital Health support.	12/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High Risk (15-16)	16	Within Risk Appetite	12	21/10/2026

ID	DCIQ ID	Risk Type	Executive lead	Risk lead	Handler	Accountable to	Reportable to	Opened	Rating (initial)	Division	Clinical Business Unit	Specialty	Hospital	Risk Title	What is the risk?	Controls in place	How is the risk measured?	Risk Reduction Plan	Date of latest risk review	Likelihood (current)	Severity (currently)	Risk level (current)	Rating (current)	Risk Appetite	Risk level (acceptable)	Review date
Strategic Objective									**1a (i) Improve patient safety**																	
4855	207	Physical or psychological harm	Group Chief Operating Officer	Chantry, Chris	Marshall, Lisa	Patient Safety Group		10/02/2022	16	Family Health	Women's Health and Breast CBU	Breast Services		Delayed diagnosis of breast cancer and increased waits to treat confirmed cancers	As a result of insufficient staffing levels and limited clinic capacity within the Breast Service, Pathology and Oncology, there is a risk that patients will not be reviewed in a timely manner following referral, diagnosis of breast cancer will be delayed and waiting times for treatment once cancer is confirmed will increase, which would result in increased patient harm. This may also result in staff fatigue due to the need to run additional clinics to mitigate delays, potentially impacting staff wellbeing and service sustainability.	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. Risk Summit held April 2026, with fortnightly meetings following on, to develop a recovery plan and monitor progress against this. PMO resource has been formally requested by Deputy COO to support this work. A new breast cancer referral triage pathway has been agreed at specialty governance and risk summit which prioritises the highest clinical risk patients, and redirect to breast pain or family history pathways where appropriate.	Volume of referrals and clinic capacity. 2ww performance / average wait time for first appointments. 62 day performance. MDT staffing levels / absence rates.	Exploration of creating additional capacity through redesign of clinic facilities, etc. Business case to be re-reviewed and resubmitted for investment round 2026/27. Develop and implement Breast Services Recovery Plan, with short, medium and long term actions to address fragility of service.	28/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	4	28/10/2026
5800	994	Physical or psychological harm	Group Chief Operating Officer	Carter, Mr Damian	Carter, Mr Damian	Patient Safety Group		15/06/2026	20	Corporate	Chief Operating Officer	Operations - Acute		Delayed Issue of Clinic Letters Due to Clinical Typing Backlog	As a result of a backlog in clinical typing across multiple specialties within the Trust, there is a risk that clinic letters are significantly delayed in being issued to patients and their GPs. This may lead to patients and GPs not receiving timely information regarding procedures or treatment plans, resulting in delays in clinical decision-making, failure to action requests, and potential harm to patients.	With the implementation of the PSH, Letter production is now centralised and managed by a dedicated team for the specialities that have transferred over. There are robust KPIs with leadership oversight of delivery. Backlogs and urgency are monitored daily and resource allocated as required. As yet, not all specialities have been centralised and oversight for these remain with the relevant care groups.	BI daily monitoring report Outstanding Dictations - BigHand Dashboard - Power BI	Action 1. Outsourcing transcription 35000 letters to Big Hand to commence 6 July 2026. Lead: Damien CarterCompletion date: 31 August 2026. Action 2. Internal team resource to be increased by utilising bank and agency to maximise productivity. Lead: Damien CarterCompletion date: Ongoing	28/08/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	4	28/09/2026

5101	487	Physical or psychological harm	Group Chief Integration Officer	Rivett, Kate	Herath, Dr Durga	Children & Young Persons (CYP) Oversight Group	Clinical Effectiveness Group	14/03/2023	20	Family Health	Children and Young Persons CBU	Paediatric Medicine	Trust-wide	Delivery of paediatric epilepsy pathways-Acute Paediatrics & Community	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;	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.	28/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	28/10/2026
5016	22	Physical or psychological harm	Group Chief Operating Officer	Skinner, Maxine	Hamer, Fiona	Patient Safety Group		02/09/2022	25	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	Emergency Department Overcrowding Resulting from Demand Exceeding Capacity	As a result of sustained demand exceeding capacity, insufficient inpatient bed availability, and overcrowding within the Emergency Departments and waiting areas there is a risk that patient flow cannot be maintained and patients awaiting assessment or treatment do not receive appropriate observation and clinical oversight. This may result in prolonged waits, delays in care and treatment, delayed identification of patient deterioration, avoidable patient harm, poor patient and staff experience, and reputational impact for the Trust.	Streaming of patients to appropriate other locations: - 'National Criteria to Admit' flowchart embedded in the ED's 'Pit stop' model to enable assessment of all EMAS attendances and stream to appropriate locations other than ED; - Medical SDEC available, open 08:00-22:00; - Medical SDEC co-located with Surgical SDEC, open 08:00-20:00; - 24 hour UTC co-located with ED at Pilgrim and Lincoln; - Clinical Decisions Unit (CDU) operationalised and opened providing 30 chairs 24 hours a day at Lincoln. This is an expansion of the Urgent & Emergency footprint (utilising what used to be clinic 11, Orthopaedic outpatients). Access to CDU is governed by agreed SOP; - MEAU 20 chairs opened to reduce overcrowding in the ED and provide improved care experience. Access is governed by agreed SOP. Patient identification and follow-up: - Different coloured chairs for UTC patients and ED patients; - Different coloured wristbands for UTC patients (Green) and ED patients (White); - Screens that screen and zone UTC & ED areas. Patients cared for in zones depending on their criteria with signed segregation; - CareFlow updated to reflect which zone patients are in, streaming arrangement	Real time oversight: - ED Risk Tool - updated 4 times daily with an overview of the department; - Capacity Meetings to dynamically risk assess; - Datix incident reporting via governance routes; - QID daily feedback for immediate mitigation of risk; - Weekly QID governance meeting where themes are discussed and learning shared to prevent reoccurrence of issues. Performance and Risk oversight: - Monthly PRM scorecard to track performance from both harm and constitutional standards; - Matron audit dashboards reporting into corporate nursing team for assurance and escalation; - Harm reviews carried out for 48 hours breaches and four hour ambulance offloads.	Action 1: Moving to acuity scoring which will allow the primary assessor to directly screen patient away from the emergency department embedding the Lincolnshire Life and Limb process. We are also considering digital solutions. Completion Date: November 2026. Action 2:Safe Care is being developed to track acuity vs staffing-Completion: January 2027 Action 3:Working with workforce colleagues to recruit into vacancy numbers-Completion December 2026. Action 4:Review of boarding areas to be carried out, this will review current boarding areas in clinical areas to enable patients to move out of ED's at times of overcrowding. Completion Date October 2026.	16/09/2026	Quite likely (4) 71-90% chance	Extreme (5)	Very high risk (20-25)	20	Above risk appetite	10	16/10/2026

4746	121	Physical or psychological harm	Group Chief Operating Officer	Rojas, Mrs Wendy	Knapp, Chris	Patient Safety Group	Outpatient Improvement Group, Patient Safety Group	14/01/2022	20	Surgery	Head & Neck and Ophthalmology CBU	Ophthalmology		Overdue patients on Ophthalmology PBWL	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	Need to ensure future sustainability once recovered.	29/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	4	29/10/2026
4879	28	Physical or psychological harm	Group Chief Operating Officer	Carter, Mr Damian	Hobson, Louise	Patient Safety Group		28/03/2022	20	Corporate	Chief Operating Officer	Cancer Centre	Trust-wide	Recovery of planned care cancer pathways	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.	-Compliance with National Cancer Waiting Time standards and NHS Planned Care guidance -Established ULTH cancer pathways, booking processes and Patient Tracking Lists (PTL) -Cancer Harm Assessments as apart of the Trust's overarching Clinical Harm Review process is in place to assess and respond to delays Governance and Oversight: -ULTH Planned Care Oversight Group - Monthly -Clinical Business Unit Performance Meetings - weekly -Care Group Performance Review Meetings -Patient Safety Response Panel (Harm Assessments) - weekly -Integrated Performance Report to Trust Board - monthly -Finance and Performance Committee - monthly -ULTH Cancer Performance & Cancer Oversight Meeting - weekly"	-Percentage of patients breaching national cancer waiting time standards (28-Day FDS, 31-Day, 62-Day, 104-Day) -Median waiting times for key diagnostics and treatment pathways, for example, diagnostics, surgery -Number of patients waiting >62 days without a confirmed treatment plan -Volume and themes of Cancer Harm Assessments with pathway delays"	- Delivery of a recovery trajectory to reduce 28-Day FDS, 31-Day, 62-Day and 104-Day breaches -Weekly Cancer Performance & Cancer Oversight Meeting at tumour-site level to monitor delivery, identify risks, and implement targeted mitigations -Trust-wide and tumour-specific trajectories established for FDS, 31-Day and 62-Day standards, aligned to the National Cancer Plan Targeted backlog reduction plan focusing on long waiters and clinically prioritised high-risk patients -Continued focus on diagnostic and treatment capacity constraints (radiology, surgery, radiotherapy) -Continued focus on the booking of patients new or follow up appointments through the Patient Service Hub"	30/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	30/10/2026

5795	996	Physical or psychological harm	Group Chief Operating Officer	Cullum, Kelly	Chamberlain, Leanne	Patient Safety Group		29/05/2026	20	Surgery	Head & Neck and Ophthalmology CBU	Orthodontics	Trust-wide	Lack of consultant staffing for Orthodontic service	As a result of the resignation of the two current consultants and a national shortage of orthodontists making recruitment difficult, there is a risk that the Trust will be unable to provide a timely and clinically effective Orthodontic service to current patients who are in the middle of the treatment pathway or to newly referred patients. This would lead to patient harm and reputational damage.	ICB service change process completed to pause new referrals	Waiting list volumes RTT performance DNA rates complaints and PALS Discharged from treatment surgery completed outcomes incident reporting staff sickness and retention	Develop a comprehensive communication plan for patients and other key stakeholders. Work with ICB to explore options for support from primary care and other acute Trusts within the region for the most complex and clinically urgent patients. Risk stratification of existing and new patients to identify and prioritise on the basis of clinical need, with highest risk patients referred to tertiary centres. Exploration of long-term service reconfiguration / decommissioning options Retention discussions with existing workforce - redeploy staff where possible	29/09/2026	Extremely likely (5)	>90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	29/10/2026
5002	535	Service disruption	Group Chief Integration Officer	Cooper, Mrs Anita	Edwards, Mrs Jill	Patient Safety Group	Palliative/End of Life Care Oversight Group, Patient Experience and Involvement Group	23/08/2022	16	Alliance	Cancer Services CBU	Specialist Palliative Care	Trust-wide	Patient access to specialist palliative care	Due to significant under-resourcing within the Specialist Palliative Care service, the organisation is unable to fully comply with the Health and Care Act, NHS England service specifications, NICE guidance and Integrated Care System requirements. This has resulted in reduced access to, and inequitable provision of, specialist palliative care for patients, carers and healthcare professionals. The resulting risk includes patient harm arising from delayed assessments, prolonged hospital stays, increased readmissions and patients dying outside their 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	Business Case written and awaiting CRIG invitation - Sarah Chester-Buckley - June 2027 Development of SPC SOP, job plan for CNS & business continuity plan - Jill Edwards - November 2026 Sustainable services review to be updated. Jill Edwards - January 2027	18/09/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	18/12/2026

5614	825	Service disruption	Group Chief Integration Officer	Fulloway, Mr Ian	Woods, Mr Michael	Children & Young Persons (CYP) Oversight Group		04/03/2025	16	Alliance	Diagnostics CBU	Audiology	Trust-wide	Paediatric Audiology Service not meeting the Paediatrics Quality Standards	As a result of Increasing demand on referrals to the service, the Paediatric Audiology Service not meeting the Paediatrics Quality Standards and the consequence of the requirement to attain UKAS IQIPS accreditation, due to insufficient staffing, capacity and lack of soundproofing rooms (the room at Boston has recently been condemned after IQUIPS benchmarking visit which has reduced capacity further) there is a risk of 1) an increase in waiting times which is a causing a delay in patients being seen and a delay in treatment which could lead to long term patient harm and risk of litigation and 2) the risk of the Trust not attaining accreditation which could lead to Audiology losing the contract for Paediatric Services in Lincolnshire.	Audiology team are undertaking work to bring the service up to this standard by updating or developing new policies, operating procedures and work instructions to meet the new Paediatric Quality Standard requirements. This is causing capacity pressures as staff are having to be taken out of clinical time due to the work involved in revising the required documents. Team is working to review IQUIPS standards and match requirements to policies and procedures currently in place within the department and to develop the new working practices and quality monitoring processes required. Work will then be undertaken to produce an action plan to put into place any policies, procedures or processes that are not currently embedded in service. Once action plan is complete and revised systems suitably embedded then an application will be placed to UKAS for initial assessment for department's compliance with IQUIPS standards. Clinics are pausing during testing while noise levels abate. Clinic dates have been amended to quieter clinic days. Insert earphones used for greater attenuation of external sounds. Paediatric room layout reviewed to reduce reverberation.	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.	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 "	24/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	24/11/2026
5651	871	Physical or psychological harm	Group Chief Operating Officer	Chester-Buckley, Sarah	Rigby, Lauren	Patient Safety Group		07/05/2025	16	Alliance	Cancer Services CBU	Oncology	Trust-wide	LPFT Macmillan Psychological Service provision to ULTH.	As a result of the withdrawal of funding for the East Midlands Cancer Alliance Centre for Psychosocial Health, the service will cease on 31st March 2026. There is a risk that the LPFT Macmillan Level 4 Psychological service may not be able to manage the increase in referrals with the addition of a waiting list of 66 patients coming from EMCA CPH to their service. This may result in their own waiting lists increasing substantially. There is no current plan for Level 2 psychological support training or supervision or plan for the FLO app which provides interim support for patients. This could lead to increased psychological distress and potential physical harm for cancer patients across Lincolnshire, alongside increased pressure on ULTH specialist staff to work beyond their scope of practice, resulting in moral injury, burnout, and a negative impact on patient safety and staff wellbeing. This means we will not be working in accordance to East Midlands Cancer Alliance key worker policy as we cannot provide supervision	Level 4 referrals are being directed to Macmillan LPFT There is a strategic and tactical working group that is feeding into the clinical care Directorate who is reviewing next steps. Communication has been shared. Monthly clinical supervision for Level 2 trained cancer workforce staff has been established and is being delivered by the LPFT Macmillan Psychology team. FLO Text Messaging Service (used by cancer teams to support patients) is only funded by LPFT until the end of 2026.	Datix Complaints Cancer Performance targets	ICB are completing a end to end service review for Level 4 Psychological support - Sam Lewis = December 2026	22/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	22/12/2026

4843	57	Physical or psychological harm	Group Chief Medical Officer	Rinaldi, Professor Ciro	Rinaldi, Professor Ciro	Medicines Quality and Safety Group		19/01/2022	20	Corporate	Group Chief Medical Officer			Lack of Senior Immunology expertise within Lincolnshire & resulting impact on Patient Safety and ULTH practice	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)	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	09/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	09/10/2026
4769	759	Physical or psychological harm	Group Chief Operating Officer	Rojas, Mrs Wendy	Arya, Nityanand	Patient Safety Group	Care Group Governance/PRM	14/01/2022	15	Surgery	Trauma & Orthopaedics and Vascular CBU	Vascular Surgery	Pilgrim Hospital, Boston	Insufficient staffing and ultrasound equipment within the Vascular Lab at Pilgrim	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	Business case developed for the purchase of a 3rd ultrasound machine.	25/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	25/11/2026

5095	59	Physical or psychological harm	Group Chief Operating Officer	Chantry, Chris	Anscombe, Mrs Sara	Patient Safety Group	Care Group Governance/PRM	24/02/2023	16	Surgery	Trauma & Orthopaedics and Vascular CBU	Vascular Surgery	Pilgrim Hospital, Boston	Insufficient PICC service capacity to meet increasing demand	As a result of increased demand for PICC services and insufficient capacity within the current establishment, there is a risk of delays in patients receiving timely PICC insertion and associated care, which would result in delayed treatment, reduced patient flow, prolonged length of stay, and poorer patient outcomes.	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.	Ongoing work to further develop a business case for submission to CRIG Give consideration to training of a wider network of clinicians associated with their individual service needs	25/08/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	1	25/11/2026
5617	854	Physical or psychological harm	Group Chief Operating Officer	Upjohn, Emma	Rayner, Gemma	Maternity and Neonatal Oversight Group		24/03/2025	20	Family Health	Women's Health and Breast CBU	Obstetrics		Insufficient maternity triage system	As a result of insufficiencies within the current maternity services triage system, there is a risk that not all pregnant individuals will be able to access safe and timely care, which could lead to harm to the mother and baby. A recent MNSI Escalation of Concern notification highlighted 'insufficient triage processes in place to support safe care for mothers' and 'evidence of the Trust gate keeping access to acute care'. The trust is in the process of looking to adopt the BSOTS model for triage which is the nationally recognised standard for an individualised, 24 hour service. Despite an agreed temporary uplift in staff of 2.52 wte B6 for LCH and 2.73 wte for PHB, there is still insufficient midwifery and medical staff to fully implement BSOTS. In addition to patient harm, there is also a financial risk to delivery of CNST year 7 due to business case for 12.1wte uplift in line with BR+ establishment review is still	• 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.	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.	28/09/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	28/12/2026

5306	713	Physical or psychological harm	Group Chief Operating Officer	Cooper, Mrs Anita	Rambani, Reena	Patient Safety Group	Infection Prevention and Control Group	28/08/2024	20	Alliance	Path Links (Pathology)	Microbiology (Pathology)	Trust-wide	Inadequate Specialist Microbiologist input for patient care	As a result of the inadequate resource of Microbiologists provided via the service contracted from NLAG, there is inadequate specialist input to ULH for complex cases or reviews on the correct use of high risk treatments used. This would lead to patient care being unsafe and can result in harm including death. It would also lead to extended hospital stays, readmissions, poor bed flow affecting access to Acute NHS care, increased morbidity and increases risk of antimicrobial resistance as a Public Health threat which harms our patients further. There are severe restrictions to prescribers accessing Microbiologist Specialist advice as it is now limited to Registrars, Consultants, Advanced Nurse Practitioners and GP level only that can access. This is resulting in patients being managed without the specialist required input, including for complex cases. Due to lack of Microbiologist capacity there is no pro-active input either in the form of Microbiologists	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	Trust to review Microbiologist contracting - as a matter of urgency – Ian Fulloway – December 2025 The Antimicrobial Guidelines are currently being reviewed for ULHT. To support this, the adult antimicrobial guidelines are being updated and published in two phases. Version 10 was released in June 2025, and Version 11 is scheduled for release in October 2026. A review of the paediatric antimicrobial guidelines is planned for Winter 2026 (December 2026) – Balwinder Bolla – January 2027	28/08/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	28/11/2026
5334	533	Physical or psychological harm	Group Chief Operating Officer	Upjohn, Emma	Gould, Georgina	Patient Safety Group	Estates Infrastructure and Environment Group	26/01/2024	15	Family Health	Women's Health and Breast CBU	Obstetrics	Pilgrim Hospital, Boston	Inadequate Labour Ward Theatre Provision for Time-Critical Obstetric Procedures	As a result of there being no second labour ward theatre at Pilgrim Hospital, there is a risk that women requiring time-critical theatre-based procedures will experience delays in accessing surgical intervention due to the need to transfer to Theatre 1 on the ground floor, and that clinicians may be more likely to undertake Caesarean sections to avoid late labour transfers, which would lead to maternal and neonatal harm, an increased Caesarean section rate, delays in treatment, reduced privacy and dignity during transfers through public corridors, and a poorer patient experience.	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.	A second theatre to be included within the planned labour ward refurbishment.	02/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	6	02/10/2026

4741	42	Service disruption	Group Chief Integration Officer	Lynch, Diane	Chester-Buckley, Sarah	Patient Safety Group	Care Group Governance/PRM	13/01/2022	20	Alliance	Cancer Services CBU	Oncology	Trust-wide	Fragility of Oncology Service Due to Consultant Workforce Shortfalls	As a result of lack of investment for Oncology workforce historically there is insufficient workforce to meet demand of the service (and we have recruited posts at risk above budget) which would lead to additional stress and burn out causing the remaining staff to leave. The current situation means that a different consultant covers the Boston site each day, which poses a clinical risk due to no continuity throughout the week. Unlike the Lincoln site which has the same consultant covering the ward all week. We are heavily reliant on high cost agency covering vacant posts due to the national shortage of Oncologists. If the service was to stop for specific tumour sites this would lead to significant patient harm whereby patients would have to travel following referral to neighbouring Trusts for radiotherapy and chemotherapy treatment, which in turn would put further pressure on other Trusts who could potentially collapse. Oncology is considered to be a fragile service due to consultant oncologist gaps. This is exasperated when consultants are	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	Need to undertake a fragile service review - Awaiting Trust new process for Fragile Service Review - Sarah Chester-Buckley - April 2026	23/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	23/10/2026
5533	754	Physical or psychological harm	Group Chief Operating Officer	Hamer, Fiona	Constantin, Dr Carmen	Clinical Effectiveness Group (CEG)		07/11/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	Failure of adherence to NICE Guidelines – risk of life changing disability	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	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	25/08/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	25/11/2026

5520	753	Physical or psychological harm	Group Chief Operating Officer	Marsh, David	Constantin, Dr Carmen	Patient Safety Group	Care Group Governance/PRM	11/10/2024	16	Medicine	Cardiovascular CBU	Stroke	Trust-wide	Delays to mechanical Thrombectomy for patients presenting with large vessel occlusion/acute stroke	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.	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 allocation2	25/08/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	25/11/2026
4868	64	Physical or psychological harm	Group Chief Medical Officer	Bassi, Sangeeta	Moore, Lisa-Marie	Maternity and Neonatal Oversight Group	Medicines Quality and Safety Group	01/03/2022	16	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy		Inappropriate preparation of c-section medication	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.	1. Use of tamper proof boxes/trays being purchased - Aug 2026 2.A procedure should be developed indicating the process to follow to ensure the medicines drawn up are discarded at the end of the day. Aug 2026 LMM	29/09/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	29/12/2026

5491	701	Physical or psychological harm	Group Chief Estates and Facilities Officer	Parkhill, Michael	Bailey, Karen	Estates and Facilities Senior Management Group	Health and Safety Committee, Infection Prevention and Control Group, Patient Safety	18/07/2024	16	Corporate	Estates and Facilities	Estates	Trust-wide	Risk of Clinical treatments being carried out in rooms that do not have the appropriate ventilation levels.	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.	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	10/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	09/10/2026
5504	716	Regulatory compliance	Group Chief Operating Officer	Fulloway, Mr Ian	Belk, Carolann	Clinical Effectiveness Group (CEG)	Care Group Governance/PRM, Estates Infrastructure and Environment Group	02/09/2024	9	Alliance	Diagnostics CBU	Endoscopy	County Hospital, Louth	Failure of Call Bell System at Louth Site – Risk to Patient Safety and JAG Accreditation	As a result of the absence of a functioning patient call bell system at the Louth site (current system cannot be repaired as replacement parts are unavailable because of its age), there is a significant risk of non-compliance with JAG standards, potentially leading to loss of accreditation. This also creates a clinical safety risk, as delays in summoning assistance during a medical emergency could occur, increasing the likelihood of patient harm. Additionally, patients who have received sedation are at heightened risk of falls due to the lack of a nurse call system	Patients are chaperoned by two members of staff within procedure room over and above Endoscopist. Recovery areas are staffed by registered nurses as per JAG requirements. Bed rails in situ to help prevent falls.	Datix incidents JAG visit / outcome	Property Services at Louth are sourcing a supplier and looking to install a new call bell system - Pete Kerman (Property Services) is leading on this - November 2026	12/08/2026	Extremely likely (5)	>90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	3	12/11/2026

5801	995	Regulatory compliance	Group Chief Operating Officer	Upjohn, Emma	Garratt, Amy	Maternity and Neonatal Oversight Group		17/06/2026	15	Family Health	Women's Health and Breast CBU	Obstetrics		Failure to achieve training compliance for CNST Maternity Incentive Scheme	As a result of a change in the CNST Maternity Incentive Scheme expectations for Year 8 (2026-27), requiring two training compliance checkpoints rather than one, there is a risk that the Trust will not achieve the 90% minimum target across all relevant staff groups by July 2026. This would lead to a failure to attain the MIS Core Standards, loss of the associated financial rebate on CNST contributions, reduced assurance regarding staff competency and patient safety, and reputational damage.	Agreement in principle to deliver all required training outlined in the CCFv2, planning currently ongoing to support delivery e.g. potential for requirement to increase establishment to facilitate release for training. Training plan in place to ensure enough capacity for delivery. Monthly reporting to Divisional Clinical Governance and upward reporting to MNOG. Agreement to support travel expenses for staff required to attend training at non-base location. Rooms booked for the next 12 months to ensure access to venues for training that is required to be face-to-face.	Monthly training statistics collated, shared and escalated as needed.	Review all staff bookings, monthly training statistics and escalate as indicated.	23/09/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	6	23/12/2026
5433	646	Physical or psychological harm	Group Chief Integration Officer	Upjohn, Emma	Marshall, Lisa	Patient Safety Group	Care Group Governance/PRM	08/05/2024	8	Family Health	Women's Health and Breast CBU	Gynaecology		Insufficient EPAU scan capacity	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 at times of extreme pressure, patients may be waiting up to 2 weeks for an appointment as the demand fluctuates regularly based on referrals. This increased waiting time may cause psychological harm during a very emotional and worrying time for a patient but can also result in physical harm as not all treatment options may not be open to the patient by the time they are seen.	24 hour emergency service is available via GAU. Patients offered scan at either site to maximise use of available scan capacity. Weekend scanning undertaken at a cost pressure where possible. EPAU nurse has completed sonography training but remains in a preceptorship period currently so limited impact on scan availability at the moment.	Complaint data PALS enquiries Patient and staff feedback	Explore options for increasing to a 7 day service at each site, with a phased increase in capacity starting with one additional day at first. Explore utilisation of CDCs to support scan delivery - this will also assist with the separate risk of patients who are potentially losing their baby from having to access care in Maternity areas where there are heavily pregnant women and babies.	21/08/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	4	21/11/2026
5196	309	Regulatory compliance	Group Chief Operating Officer	Bassi, Sangeeta	Moore, Lisa-Marie	Medicines Quality and Safety Group	Medicines Quality and Safety Group	20/06/2023	15	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy		Non-compliance with medicines storage audits	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.	Rewrite new Medicines Safety Risk and look to close this one LMM/LH August 2026	20/07/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	4	20/10/2026

5146	277	Physical or psychological harm	Group Chief Operating Officer	Upjohn, Emma	Marshall, Lisa	Patient Safety Group	Care Group Governance/PRM	13/04/2023	9	Family Health	Women's Health and Breast CBU	Gynaecology		Termination of pregnancy service currently unable to meet RCOG standards	As a result of insufficient scanning capacity, the termination of pregnancy service is currently unable to meet RCOG standards resulting in reduced patient experience and potential psychological harm. This is also a reputational risk to the trust due to non-compliance with standards.	The Home termination of pregnancy service has been implemented but further work is required to fully implement telemedicine support for this. Additional weekend clinic capacity used for TOP scans where possible.	Monitoring number of patients unable to receive service at the trust and have to be referred elsewhere. Undertaking patient feedback requests and questionnaires to ascertain patient's voice to improve service.	Full implementation of telemedicine service, including development of a SOP, as this will enable some patients to have a termination without the requirement for a scan. General Manager working with the ICB to ensure that they have accurate and correctly coded activity data to support their commissioning decisions.	28/09/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	3	28/10/2026
5181	358	Physical or psychological harm	Group Chief Integration Officer	Lynch, Diane	Rigby, Lauren	Medicines Quality and Safety Group		23/05/2023	16	Alliance	Cancer Services CBU	Oncology	Trust-wide	SACT capacity does not meet demand	As a result of chemotherapy units at PHB and LCH consistently operating below the recommended nurse staffing levels set by EMCA—requiring 14 nurses per day at PHB and 17 per day at LCH, but typically having only 8 and 9 respectively and inadequate space and an increase in available treatments particularly oral treatments, SACT capacity does not meet the demand required which would lead to the Trust being unable to meet our 31 and 62 day cancer targets, psychological distress to patients due to waiting time and staff burn out due to working conditions. Pilgrim does not have a medical day unit (MDU), our SACT services therefore have to run differently to Lincoln. Chemotherapy Suite at PHB has 18 Chairs which could all be utilised for SACT delivery however, as we do not have an MDU these are used for transfusions, picc flushes etc.	OAU used in appropriately at times, patients admitted to wards if time critical. Staff work extended hours Patients waiting 3 weeks or more are escalated to Matron	Datix incidents Complaints / PALS Staff concerns Sickness absence Retention figures 31 & 62 day targets	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	14/09/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	6	14/12/2026
Strategic Objective									**1a (ii) Improve patient experience**																						

5003	342	Physical or psychological harm	Group Chief Integration Officer	Cooper, Mrs Anita	Edwards, Mrs Jill	Care Group Governance/PRM	Palliative/End of Life Care Oversight Group, Patient Safety Group, Workforce Strategy	23/08/2022	16	Alliance	Cancer Services CBU	Specialist Palliative Care	Trust-wide	Workforce deficit for Specialist Palliative Care	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 All staff aware of the Employee Assistance Programme offer. Flexible working arrangements in place where required	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	Business Case written awaiting CRIG invitation - Sarah Chester-Buckley - June 2027.	18/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	18/12/2026
5216	362	Physical or psychological harm	Group Chief Operating Officer	Cooper, Mrs Anita	Brown, Paula	Clinical Effectiveness Group (CEG)	Radiation Protection Committee	14/07/2023	12	Alliance	Cancer Services CBU	Radiotherapy	Trust-wide	Radiotherapy Staffing levels	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	We will seek funding for some supernumerary salary support for radiation engineers in the coming years – Patrick Downes – June 2026 Business Cases will be developed to meet service needs – Patrick Downes – July 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 – July 2026	21/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	21/10/2026

5495	725	Physical or psychological harm	Group Chief Operating Officer	Upjohn, Emma	Bond, Rachel	Maternity and Neonatal Oversight Group	Estates Infrastructure and Environment Group, Patient Experience and Involvement	07/08/2024	16	Family Health	Women's Health and Breast CBU	Obstetrics	Lincoln County Hospital	Lack of adequate provision for appropriate care of bereaved families with Obstetrics	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	Specific bereavement facilities to be included as part of proposed redevelopment of labour ward - unknown timeframe.	02/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	02/10/2026
5227	439	Regulatory compliance	Group Chief Operating Officer	Lynch, Diane	Hughes, Robert	EIEC	Clinical Effectiveness Group, Estates Infrastructure and Environment Group	02/08/2023	12	Alliance	Path Links (Pathology)	Mortuary (Pathology)	Trust-wide	Risk of unauthorised entry into the Trust's mortuary and/or temporary body stores	As a result of inadequate physical security and access controls in the Trust's mortuary departments, there is a risk that unauthorised individuals could gain entry, which would lead to a breach of patient dignity, potential damage to bodies (either deliberately or due to environmental control failure), regulatory reporting to CQC and HTA, criminal investigations, possible fines, sanctions, or revocation of the mortuary licence, complaints and claims from families, and significant reputational damage to the Trust.	24 hour site security: Walkarounds in place, with security tags fitted to exterior of mortuary buildings; additional security patrols at night CCTV: On entrance to Mortuary departments Access Control: Swipecard access to main mortuary departments (governed by SOPs). Alarm system: All 3 sites main mortuaries have intruder alarm that is connected to the Switchboard. Security review undertaken June 2026 External security review commissioned as part of Martyn's Law & Fuller Enquiry for Q2 2026.	Incident reporting Access Audits from CCTV reviews Monthly audits on who has access permissions.	Take appropriate actions as part of security review, following presentation of the findings to security management group and HTA Governance. Lead Keiron Davey Completion Date: Jan-March 2027.	28/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	28/12/2026

5825	1027	Physical or psychological harm	Group Chief Operating Officer	Chantry, Chris	Bond, Rachel	Maternity and Neonatal Oversight Group		21/08/2026	16	Family Health	Women's Health and Breast CBU	Obstetrics		Lack of access to a compliant perinatal post-mortem pathway	As a result of Nottingham University Hospitals NHS Trust being unable to deliver the contracted perinatal post-mortem service, and with no agreed alternative provider or process currently in place, there is a risk that parents may not be offered the option of a post-mortem examination in accordance with best practice, that fully informed consent for third-party involvement may not be obtained, and that inaccurate or inconsistent information may be provided regarding the location of their baby and expected post-mortem timescales. Delays in arranging and undertaking post-mortem examinations may also occur, potentially leading to deterioration of the deceased baby and limiting opportunities for families to see their baby following the procedure. This would result in significant parental distress and psychological harm, a poor bereavement experience, reduced confidence in maternity and neonatal services, and potential non-compliance with professional and legal standards relating to consent	We are currently still able to send babies to NUHT, where the bodies will be cared for until such time that a post mortem can be undertaken. Post mortems are being done by third parties on an ad hoc basis, however there is a potential for this to cause an information governance breach as parental consent for post mortem cannot be fully informed as the third party details are not known when consent is obtained.	Incident reporting Patient complaints Contractual compliance monitoring	Urgent meeting being arranged with NUHT to seek immediate assurances and discuss their plans for recovery. Work with Contracts team to explore other possible provider options for short-term and following the end of the current contract with NUHT.	16/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	16/12/2026
Strategic Objective									**1a (iii) Deliver clinically effective care**																			
5796	1015	Physical or psychological harm	Group Chief Operating Officer	Wright, Jo	Chamberlain, Liz (Elizabeth)	Care Group Governance/PRM		29/05/2026	20	Surgery	PACT - (Pre-assessment, Anaesthetics and Pain, Critical Care and Theatres) CBU	Anaesthetics	Lincoln County Hospital	Delayed response to Anaesthetic emergencies due to insufficient middle grade establishment	As a result of the lack of establishment for middle grade staffing during out of hours periods, there is a risk that the team will be unable to effectively respond to Anaesthetics emergency calls in a timely manner which would lead to permanent patient harm or death. There is also a service disruption impact across the Trust as other specialities will be required to dedicate more of their resource to support and manage those patients until Anaesthetics input is available.	Requests are made to existing off duty staff to come in and support with out of hours emergency activity via group messages and phone calls which may not be responded to and this is time consuming. This is not efficient or sustainable as it relies on the good will of those staff and also prevents them from fully benefiting from the rest periods to which they are entitled.	Incident reporting Patient complaints Sickness absence monitoring	Develop a business case for the introduction of an out of hours middle grade establishment to support existing consultant establishment.	19/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	19/11/2026

5747	944	Physical or psychological harm	Group Chief Operating Officer	Hamer, Fiona	Venugopal, Mr Vinod	Patient Safety Group		23/01/2026	20	Medicine	Cardiovascular CBU	Cardiology	Trust-wide	Risk of Patient Harm and Regulatory Non-Compliance Due to Insufficient Cardiac Catheter Laboratory Capacity	As a result of the sustained lack of available cardiac catheter lab space for both PCI and device procedures—driven by rising inpatient flow pressures, emergency admissions, and the displacement of elective activity—there is a risk that elective PCI and device waiting lists will continue to grow, leading to increasing P2 and P3 breaches, an inability to maintain safe balance between inpatient and elective demand, prolonged delays in clinically time-sensitive procedures, and failure to meet NICE/MINAP standards resulting in avoidable patient harm, further increases in acute admissions and inpatient length of stay, service destabilisation, and serious regulatory exposure for the Trust, including the potential for a Regulation 28 “Action to Prevent Future Deaths” notice should a patient die while awaiting PCI or device implantation.	Some PCI patients are being medically managed but the delay in waiting for procedures can affect their condition and can result in admissions through the emergency route while they wait for elective treatment. Electives are being cancelled as needed to accommodate IP demand.	Outpatient waiting list Inpatient length of stay MINAP data-latest data shows we are only completing 60% of inpatient PCI within the NICE recommended target of 72 hours.	Action 1. No mitigation is possible without the availability of “separate” elective and urgent/hot lists. Until then cases are risk stratified and listed in order or clinical urgency. Action 2. Development of a business case for a third lab timed in with the replacement of the existing labs which is overdue. This will ensure minimum disruption during refurbishment and future proofing the service Completion date: Jan 2027	25/08/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Above risk appetite	8	25/11/2026
Strategic Objective									**1b: Reduce waiting times for our patients**																			
5447	691	Service disruption	Group Chief Operating Officer	Rojas, Mrs Wendy	Daniels, Mrs Samantha	Patient Safety Group	Workforce Strategy Group	05/06/2024	16	Surgery	PACT - (Pre-assessment, Anaesthetics and Pain, Critical Care and Theatres) CBU	Theatres		Insufficient theatre staffing resulting in elective list cancellations and delays	As a result of insufficient theatre nurse staffing levels that do not support current activity, alongside the cessation of off-framework staffing arrangements and ongoing recruitment challenges, there is a risk of elective theatre lists being delayed or cancelled due to a lack of available theatre staff. This would result in increased patient cancellations, longer waiting times, reduced theatre capacity, potential failure to meet elective recovery targets, and a negative impact on patient experience and organisational performance.	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	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.	26/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	26/11/2026

4891	417	Service disruption	Group Chief Integration Officer	Fulloway, Mr Ian	Clapham, Mrs Sarah	Patient Safety Group	Radiation Protection Committee	01/04/2022	12	Alliance	Diagnostics CBU	Clinical Imaging	Trust-wide	Following termination of AQP - Ultrasound capacity not meeting demand	As a result of the ICB issuing notice to terminate the ultrasound AQP contract with Diagnostic Healthcare (DHC) from 1 April 2025, leading to all NOUS referrals being redirected to ULHT as the lead provider—an estimated increase of approximately 1,000 additional referrals per month, there is a service disruption risk and a risk that ULHT will be unable to meet DM01 diagnostic performance targets, resulting in delays in patient diagnosis with potential for patient harm, as well as reputational damage to the Trust due to prolonged waits.	1) To manage increased demand, staff are completing additional out-of-hours scanning sessions, including weekend working, supported by agency staff where required.	Monitoring performance / demand for ultrasound Staffing levels in Ultrasound Datix incidents Patient complaints / PALS Staff satisfaction survey	Medicare currently in place to reduce waits, Medicare are providing locums to staff ultrasound room-started 21st June. They have a trajectory to reduce by 1500 a month. Currently has a years contract-Ongoing-Gemma Webb. Harms Review to be carried out and to be aligned with oversight processes- Anita Cooper-Ongoing.	16/09/2026	Extremely likely (5)	>90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	6	05/10/2026
5715	919	Physical or psychological harm	Group Chief Integration Officer	Fulloway, Mr Ian	Clapham, Mrs Sarah	Workforce Strategy Group	Patient Safety Group	21/10/2025	12	Alliance	Diagnostics CBU	Radiology	Trust-wide	Reduction in staffing levels within CT, ultrasound and MRI administration teams	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	Recruit into the vacant posts that have not been affected by MARS - Sarah Clapham - March 2026	09/09/2026	Extremely likely (5)	>90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	3	09/12/2026
Strategic Objective									**1c: Improve productivity and deliver financial sustainability**																		
5020	6	Finances	Group Chief Operating Officer	Skinner, Maxine	Thomson, Cheryl	Workforce Strategy Group	WORK	02/09/2022	20	Medicine	Urgent and Emergency Care CBU			Reliance on agency / locum medical staff in Urgent & Emergency Care	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	Action 1: Tier 2 rota being developed. Completion Date: Ongoing Action 2: Financial meetings continue from a risk point of view weekly with all senior team within medicine care group. Completion Date: Ongoing Action 3: Medical TSSG meetings to highlight any risks to raise any possible risks to Director of Ops. Completion Date: Ongoing	16/09/2026	Quite likely (4)	71-90% chance	Extreme (5)	Very high risk (20-25)	20	Above risk appetite	10	16/10/2026

5389	559	Finances	Group Chief Operating Officer	Capon, Mrs Catherine	Anderton, Kerry			19/02/2024	20	Corporate	Chief Operating Officer			Risk of overspend due to current service provision being unfunded-Hospital at Night	Risk of overspend due to current service provision being unfunded. Also overspend due to increased sickness leading to a higher requirement for bank, agency and Overtime. Increased insurance due to increased litigation. Due to patient complaints and safety aspects.	Monthly budget reviews, and recognised overspend.	Datix, through finance reviews.	Case of Need to be heard by CRIG on the 26th March 2024, following which a business case to be submitted.	13/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	6	13/10/2026
5793	991	Finances	Group Chief Finance Officer	Antunes Goncalves, Paul	Sargeant, Paula	Capital, Revenue and Investment Group (CRIG)		26/05/2026	20	Corporate	Finance and Performance	Operational Finance	Trust-wide	Risk of failure to deliver the ULTH CIP target in full for 2026-27	As a result of possible delays to planned efficiency schemes, the non-viability of identified opportunities at the required pace, and the complexity of implementing savings plans during a period of significant organisational transformation, there is a risk that the Trust will not deliver the £81m efficiency requirement set out in the ULTH financial plan, which could lead to reduced financial sustainability, failure to meet statutory financial duties, reputational damage to the Trust, and a deterioration in the NOF rating. In addition, as a result of the strategic direction to left-shift activity in line with the 10-year "Acute to Community" plan, which crosses statutory organisational boundaries and relies on joint working, there is a risk that the Group-managed CIP results in uneven delivery across organisations, which could lead to one organisation over-delivering efficiencies while another under-delivers against its statutory duties	National policy: - NHS annual budget setting and monitoring processes - Breakeven Plan - NHS monitoring status and development of schemes. - Acute to Community, Analogue to digital. ULTH policy: - Detailed Financial plan inclusive of the headcount reductions has been submitted and ownership is in place for delivery. - 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. ULTH governance: - Detailed CIP reporting via PMO software (Monday.com) supported by QIA process at Productivity, Improvement, Transformation Oversight Forum (PITOF)	The Trust is monitored externally against the Trust CIP target through the monthly finance return to NHSE. For 2026/27 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.	Action 1. Working with Corporate and Operational colleagues to clearly identify CIP schemes. Lead: Paula SargeantCompletion date: 30th June 2026. Action 2. Increased CIP governance & monitoring arrangements through PRM's to ensure oversight (including additional one off detailed executive review sessions with care groups as required) weekly reports into ELT and introduction of Monday.com. Lead: Paula SargeantCompletion date: 31st March 2027 Action 3. Alignment with the Group Strategy for Acute to Community, Digital to Analogue. Lead: Paula SargeantCompletion date: 31st March 2027 Action 4. Continued focus on exploration of new opportunities and development of future	28/09/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	28/12/2026
4658	17	Reputation	Director of Corporate Affairs	Warner, Jayne	Hobday, Fiona	Information Governance Group	Digital Hospital Group	10/01/2022	20	Corporate	Corporate Affairs	Information Governance	Trust-wide	Failure to meet national standards and best practice for record management	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.	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.	01/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	01/10/2026

Strategic Objective									1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda																	
5272	455	Physical or psychological harm	Group Chief Operating Officer	Hamer, Fiona	Miller, Mrs Sally	Estates and Facilities Senior Management Group	Estates Infrastructure and Environment Group	06/10/2023	12	Medicine	Cardiovascular CBU	Cardiology	Lincoln County Hospital	Risk of patient harm due to Cath Labs coming to end of life and lack of emergency power resilience.	As a result of the current Cath Labs coming to end of life and Lincoln Cardiac catheter lab not being connected to the emergency power supply at Lincoln County Hospital, power cuts and faults due to breakage may occur. This would lead to potentially being unable to offer a PPCI service (primary percutaneous cardiac intervention) and possible risk of patient harm, death or possible implications around infection if a patient is undergoing a procedure at a time of a power cut. Parts not being able to be sourced may put inpatients for angioplasty and pacing procedures at risk and cause significant disruption across the service In addition, Cardiology is trying to build a case for a 3rd lab due to lack and ability and being able to maintain emergencies and piece of work is being undertaken on lab efficiency to help inform the case for. Currently there is nowhere currently on the Lincoln site for a 3rd lab A large proportion of patients waiting for TAVI (Trans Catheter Aortic Valve Implantation)	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.	-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.	06/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	1	06/10/2026
5632	836	Reputation	Group Chief Integration Officer	Fradgley, Daren	Hall, Mrs Claire	Estates and Facilities Senior Management Group	Green Plan	07/04/2025	20	Corporate	Integration and Improvement		Trust-wide	Risk of not being able to deliver the net zero emissions target (a carbon neutral position for the organisation)	As a result of the failure to take effective actions it is possible that the Group will not meet agreed NHS statutory emissions targets and meet the Group requirements around annual declaration on Climate Change which could lead to statutory regulatory action, financial penalty and reputational damage.	Group Green Plan approved by Group Board in October 2025. Undertaken the audit of the green plan actions – there would now be a report stating what we have achieved / not achieved. Engagement with the stakeholders of the areas affected and identified next step actions Group of Green champions across the organisation to support delivery against the sustainability agenda. There are in excess of 69 champions across the Group. A number of green projects are being supported by them. Improved communications – an intranet page is in place and a communication plan in place. Connect to Care focus on Green plan and leadership round to identify opportunities to focus further on the Green / sustainable agenda. LCHG Green Group (with Group Chief chair) which feeds into the Finance and Performance Committee. Launch Sustainability Impact Assessment (SIA) business as usual part of CRIG to support business case consideration and 6-stage PMO Improvement Process.	Audit of the green plans (completed - formed baseline). Carbon footprint data (now commenced). Internal NHS Providers Well-led Improvement Action plan. NHS Greener Dashboard. Sustainability Criteria in the national contract. Compliant for 2026/27. Climate Change risk assessment completion as part of the annual report. (Risk is that there is a potential of repercussion from failure to complete annual report declaration. Risk of not doing and not being able to report by Feb/Mar 2027. 2 risk assessments: LCHS and ULTH needed.)	Action 1. Reduce Nitosoxide omissions through replacement programme and replacement with Canisters. Estates to change manifolds to complete this work. Lead: Ahtisham Saddick / Estates Team Completion date: September 2026. Action 2: Carbon Baseline piece of work will produce schedule of potential projects to support identification and prioritisation of work needed to reduce carbon footprint. To present to the Green Group in September 2026 with report reporting of recommendations to Finance and Performance Committee. Action 3: Limited assurance on the delivery of the actions in the green plan and interaction with Green plan owners and to support the carbon baseline. Monday.com actions support mitigating this. Review at September 2026 Green Group.	14/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	2	14/12/2026

4725	466	Reputation	Group Chief Integration Officer	Taylor, Ruth	Taylor, Ruth	Estates and Facilities Senior Management Group	Estates Infrastructure and Environment Group	13/01/2022	20	Alliance	Therapies and Rehabilitation CBU		Lincoln County Hospital	Prolonged Estates and infrastructure issues in Therapy & Rehab department	As a result of prolonged and unresolved estates related issues, including temporary relocation of Occupational Therapy staff into Physiotherapy Department and the decanting of the Rehabilitation Medicine Team into reduced and unsuitable space at Lincoln County Hospital, staff and patients continue to be affected by environmental and infrastructure shortcomings. These include overcrowding, poor temperature control and ventilation, inadequate clinical and patient facilities, and general deterioration of furnishings and building systems. Despite being approved as a temporary measure, the situation has remained unresolved for over 12 months. There is a risk that the ongoing substandard working and treatment environment will result in reputational damage to the organisation, stemming from negative staff and patient experiences and perceptions.	Legislation: - Health & Safety at Work Act 1974 -Management of Health & Safety at Work Regulations 1992 associated guidance. ULH policy: - Health & Safety Policy & related guidance - Health & safety training (Induction, Core Learning, Core Plus Learning and CPD) - Estates Planned Preventative Maintenance (PPM) / testing - Occupational Health services ULH governance: - Health & Safety Committee / site-based H&S Forums; accountable to Trust Board through Finance, Performance & Estates Committee (FPEC) Frequent escalations to Estates Team for repairs Increased use of flexible working policy Site visits by senior Exec Team members Frequent escalations through Governance processes Ongoing review of space Curtains in place in the clinical area which will increase clinical space, which will also reduce noise levels. Staff who want to come to work in their uniform are doing so Hot desking room created in the department Increase in laptops provided so staff can go and work on the wards	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	Work with Estates to identify better facilities – Ruth Taylor – March 2027-due to staff consultation. Business Case is required to implement any service move to another space – Sandy Marley – December 2026.	17/09/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	17/12/2026
4648	2	Physical or psychological harm	Group Chief Estates and Facilities Officer	Parkhill, Michael	Davey, Keiron	Health and Safety Committee	Emergency Planning Group, Fire Safety Group, Health and Safety Committee	15/12/2021	20	Corporate	Estates and Facilities	Fire and Security	Trust-wide	Potential for a major fire	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 fire risk assessments) - tasks allocated to Estates / local managers, etc. as appropriate; tracked and monitored by Fire Safety Team	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.	- 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	13/08/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	10	13/11/2026

5234	510	Service disruption	Group Chief Integration Officer	Lynch, Diane	Biddulph, Victoria	Estates and Facilities Senior Management Group	Estates Infrastructure and Environment Group	25/08/2023	15	Alliance	Diagnostics CBU	Neurophysiology	Pilgrim Hospital, Boston	No clinic space at Pilgrim affecting Neurophysiology testing	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	Working with Estates to get costings for a permanent room – Victoria Biddulph – June 2026	05/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	05/11/2026
4701	85	Reputation	Group Chief Operating Officer	Chantry, Chris	Upjohn, Emma	Estates and Facilities Senior Management Group	Estates Infrastructure and Environment Group, Maternity & Neonatal Oversight Group,	13/01/2022	15	Family Health	Women's Health and Breast CBU	Obstetrics	Trust-wide	Hospital environment and facilities in Maternity services	As a result of the poor quality and condition of the environment and facilities within Maternity Services, there is a risk that patients may experience substandard care environments and staff morale may be adversely affected, which would lead to an increased likelihood of infection-related harm, reduced patient satisfaction, loss of public confidence in the Trust, and reputational damage.	- 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.	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.	08/09/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Above risk appetite	6	08/12/2026

4830	11	Service disruption	Group Chief Estates and Facilities Officer	Parkhill, Michael	Savill, Allen	Estates and Facilities Senior Management Group	Medicines Quality and Safety Group, Water Safety Group	17/01/2022	15	Corporate	Estates and Facilities	Estates	Pilgrim Hospital, Boston	Flooding of Pharmacy, Switchboard & Porters Lodge due to Plant and pipework failure at Pilgrim Hospital	As a result of estates plant, pipework and drainage systems located above the Pharmacy Department at Pilgrim Hospital Boston that are prone to blockage, leakage or overflow, there is a risk of flooding within the department. This could result in damage to medicines, including high-cost refrigerated and ambient stock, computer equipment and aseptic facilities, leading to loss of critical pharmaceutical services, disruption to patient care, and significant financial and operational impacts.	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	Estates to identify potential solutions to the blockage / overflow issues – Estates – March 2026	13/07/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	6	13/10/2026
5383	615	Regulatory compliance	Group Chief Integration Officer	Cooper, Mrs Anita	Rigby, Lauren	Estates and Facilities Senior Management Group	Estates Infrastructure and Environment Group, Estates Strategy Group, Health and	13/02/2024	15	Alliance	Cancer Services CBU	Haematology (Cancer Services)	Pilgrim Hospital, Boston	Treatment room not compliant with HBN 00-03 due to poor ventilation	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	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	14/09/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	3	14/12/2026

5498	726	Regulatory compliance	Group Chief Estates and Facilities Officer	Parkhill, Michael	Purdy, David	Estates and Facilities Senior Management Group	Health and Safety Committee	19/08/2024	15	Corporate	Estates and Facilities	Estates	Trust-wide	Risk of patient delays and potential risk of accidents from Trust Helipad due to location, quality and security	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	Action 1. Estates and Facilities take immediate action when notified of issues. Action 2. Working with the Hospital Emergency Landing Pad (HELP) appeal and Green Deck Operations, obtaining surveys for options and developing a business case to improve conditions and become compliant. Green Deck appeal have offered to fund the works required to existing pads once the plan is developed. Currently we need to review options available at Lincoln & Boston. Action 3. Once investment in place, Ops to work on Governance compliance for CAP1264 Civil Aviation standard. Action 4. Meeting to be had with Lee Taylor as we need to have an accurate recorded data process for recording when a helipad lands.	10/09/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Above risk appetite	3	10/12/2026
Strategic Objective									**2a: Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture**																		
5450	659	Physical or psychological harm	Group Chief Operating Officer	Hamer, Fiona	Highfield, Kimmi	Patient Safety Group		05/06/2024	12	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	Risk of Gastro service not being viable due to current fragility of Consultant workforce	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) -Large scale outsourcing of outpatient capacity to private provider	Workforce gaps Capacity of the service Cover of rota's (inpatient ward cover and on-call bleed cover)	Action 1-Develop robust recruitment plan to cover establishment gaps, including non substantive workforce. Lead: Charles Smith Completion-Ongoing Action 2-Pro-active management of rota's and gaps Lead Charles Smith Completion-Ongoing Action 3 All on call/rota gaps to go out to cover with bank and agency Lead Charles Smith Completion-Ongoing	10/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	10/10/2026
5427	699	Service disruption	Group Chief Medical Officer	Babu, Suresh	Chablani, Manish	Care Group Governance/PRM	Education Oversight Group	30/04/2024	16	Corporate	Group Chief Medical Officer	Medical Education		Student training discrepancy between Lincoln & Boston	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	Increase the workforce, investment into staff and education	19/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	19/11/2026

4780	74	Service disruption	Group Chief Operating Officer	Hamer, Fiona	Constantin, Dr Carmen	Care Group Governance/PRM	Workforce Strategy Group	16/01/2022	20	Medicine	Cardiovascular CBU	Stroke	Trust-wide	Significant deficit in stroke consultant staffing	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	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.	25/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	25/11/2026
5564	783	Physical or psychological harm	Group Chief Operating Officer	Capon, Mrs Catherine	Anderton, Kerry	Care Group Governance/PRM	Workforce Strategy Group	19/12/2024	16	Corporate	Chief Operating Officer		Trust-wide	Risk of operational pressures to Hospital Out of Hours due staffing and increase of wards.	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	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.	06/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	06/10/2026
5467	695	Service disruption	Group Chief Medical Officer	Babu, Suresh	Chablani, Manish	Care Group Governance/PRM	Education Oversight Group	21/06/2024	16	Corporate	Group Chief Medical Officer	Medical Education	Lincoln County Hospital	Respiratory Teaching Gaps at 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	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	09/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	09/10/2026

5691	905	Service disruption	Group Chief Integration Officer	Fulloway, Mr Ian	Clapham, Mrs Sarah	Care Group Governance/PRM	Workforce Strategy Group	19/08/2025	16	Alliance	Diagnostics CBU	Radiology	Trust-wide	Reduction of staffing levels within the PACS Team	As a result of reduction in staffing levels within PACS team attributable to MARS which was 1WTE 8A (with 20+ years of experience), and unfilled vacancies. This will have a significant adverse impact on service delivery across the Trust, affecting the delivery of safe patient care caused by the inability to deliver on vital projects such as Boston CDC, PACS / Web V and CRIS upgrades, importation of images to and from external parties, irefer, Phillips ROCC project, EPR, and the inability to produce data supporting monitoring of diagnostic Waiting times, inability to produce billing reports resulting in loss of income. (this list is a small representation and not exhaustive of the current PACS team workload) Due to staffing issues and unsustainable workload there has not been the capacity to be able to cross train appropriately. Requiring the team to function on the basis of defaulting back to individual strengths in order to keep the	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	Recruit into the vacant posts that have not been affected by MARS - Sarah Clapham - February 2026	12/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	12/11/2026
4789	32	Service disruption	Group Chief Operating Officer	Marsh, David	Venugopal, Mr Vinod	Workforce Strategy Group		16/01/2022	20	Medicine	Cardiovascular CBU	Cardiology		Processing of Echocardiograms	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.	-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	23/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	06/10/2026

5142	65	Physical or psychological harm	Group Chief Operating Officer	Thomson, Cheryl	Thomson, Cheryl	Care Group Governance/PRM	Workforce Strategy Group	12/04/2023	20	Medicine	Urgent and Emergency Care CBU	Accident and Emergency	Trust-wide	Inadequate Overnight Middle Grade Medical Staffing in Emergency Departments Due to Increased Demand	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. Acuity score live at Lincoln since Jan 2026 Acuity score live at Pilgrim since Feb 2026	4 hour target/12 hour breaches. Time to first assessment. Decision to admit.	ED Rota and workforce review with new rotas to provide effective cover overnight in all areas at all grades. 2026/27 Job Planning to be completed-Ongoing	28/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	9	28/10/2026
5469	697	Service disruption	Group Chief Medical Officer	Rinaldi, Professor Ciro	Chablani, Manish	Medicines Quality and Safety Group	Education Oversight Group	21/06/2024	16	Corporate	Group Chief Medical Officer	Medical Education	Trust-wide	Failure to meet contractual requirements in Pharmacy teaching	As a result of Pharmacy struggling to budget and recruit into the role whilst there are budgetary provisions on the medical education side there is a risk that without adequate educators we would fail to deliver the curriculum across the entire clinical years for years 3,4 & 5 which would lead failure of our contractual requirements and this would bring into question our newly gained status as a teaching hospital.	We are currently liasing with the Pharmacy department around the appointment of a part time prescribing skills lead. This would be a 50/50 appointment shared with the pharmacy team	Meeting reviews.	Increase the workforce, investment into staff and education	10/08/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	10/11/2026
4862	44	Service disruption	Group Chief Operating Officer	Hamer, Fiona	Smith, Charles	Care Group Governance/PRM	Workforce Strategy Group	22/02/2022	16	Medicine	Specialty Medicine CBU	Respiratory Medicine	Trust-wide	Consultant staffing capacity within Respiratory Medicine	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)	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. Business case with substantiating x 3 consultants that currently unspent budget with cover instead of relying on agency workforce- Completion March 27.	28/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	4	28/10/2026

5480	683	Service disruption	Group Chief Integration Officer	Marsh, David	Bursey, Sarah	Care Group Governance/PRM	Workforce Strategy Group	05/07/2024	12	Alliance	Outpatients & Community Medicine CBU	Endocrinology/Diabetes	Trust-wide	Risk of depleted workforce in diabetes-DSN	As a result of a depleting workforce in diabetes this is leading to withdrawal of ward work which is impacting on the quality of care that patients are receiving. Currently pan Trust Trust there should be eleven DSN nurses WTE and there is currently only two in post. Out of these two in post one is due to retire. There is currently three members of staff on maternity leave. Care is having to be withdrawn from ICU, DSN reviews and referrals. For Navenby Ward they are having to rely on junior medic workforce. Active in reach for ED is now limited due to lack of resources. This leads to the potential of missing patients. Staff education has stopped, if its not on ESR or online but no face to face is not currently possible due to work pressures.There is an impact of outpatient referrals, unless it is life threatening these are delayed till further notice which would lead to an increase in waiting lists. Unless patients are pregnant PUMP cannot be offered, there is currently a significant backlog. This risk may lead to possible	-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.	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.	24/08/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	2	24/11/2026
Strategic Objective									**2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation**																	
5093	40	Service disruption	Group Chief Medical Officer	Bassi, Sangeeta	Martinez, Francisca	Medicines Quality and Safety Group	Medicines Quality and Safety Group, Workforce Strategy Group	16/02/2023	20	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy	Trust-wide	Risk to Medicines Availability and Financial Sustainability Due to Pharmacy Support Staff Vacancies	As a result of the pharmacy procurement staffing establishment not meeting the demands of the service due to demonstrable year on year increases in procurement activity and the rise in drug shortages, there is a risk that any annual leave or sickness absence on a backdrop of current vacancies, gaps in the team associated with MARS approval by the Trust during 2025/26, and several long term absences within the invoicing and pharmacy stores teams will result in workload exceeding available capacity to maintain medicines ordering and invoice processing across all sites, resulting in negative impacts on staff wellbeing, disruption to the supply of medicines (including IV fluids, medical gases and chemotherapy), delays in invoice payment leading to financial penalties or supplier account holds, and failure to deliver biosimilar switches and CIP targets (£500K) for 2026/27.	Currently no controls in place	Staff Survey Staff Feedback Staff sickness Finance performance on invoice payment Workload CIP tracking Biosimilar switching targets Accounts on hold Invoice amount outstanding Stock take completion percentage Ordering lines Recall and shortage numbers	Vacancy fulfillment - QIAs for 0.4 band 3 submitted; jobs offered in progress to agree start dates - Andrew Baines - September 2026 (dependant on funding) Staff trained and competent to fulfil roles (Goods receipt training has been completed, stock issuing assessment still to be done) - now aiming for June completion (Colin Bell) Plan to increase monitoring of invoicing activity and backlog to weekly from May to assess impact of the maternity leave; support offered by LCHS pharmacy with this work for a three month period commencing end of May (but member of staff will require training to be able to fulfil the required work). Agreement received to recruit at risk for posts in invoicing and purchasing; recruitment is underway	29/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	4	29/10/2026

4844	38	Service disruption	Group Chief Medical Officer	Bassi, Sangeeta	Saddick, Ahtisham	Care Group Governance/PRM	Medicines Quality and Safety Group, Workforce Strategy Group	19/01/2022	20	Corporate	Group Chief Medical Officer - Pharmacy CBU	Pharmacy	Trust-wide	Risk of patient harm from restricted Pharmacy cover and workforce shortfalls (including seven-day service)	As a result of the current Pharmacy service provision operating limited hours (9–5 Monday–Friday and reduced or no weekend cover across sites), combined with workload cut-off times for supplies and a pharmacy establishment that is 84 WTE below national benchmarks, there is a risk that patients requiring critical medicines, discharge supplies, or pharmacy medication review in core hours (with no clinical pharmacy cover outside these hours). Patients do not receive timely pharmacy input, resulting in delayed or omitted medications, delayed discharges due to inadequate discharge planning, increased readmissions, potential patient harm, and additional financial pressures from the use of FP10s, alongside reduced provision of safe and timely care owing to the lack of dedicated out-of-hours pharmacy support in clinical and admissions areas when compared with peer Acute Trusts.	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 Monitor sickness rates following weekend working Staff Survey results Medicines reconciliation figures Staff exit interviews Omitted and delayed doses secondary to pharmacy Ward cover heat map	Risk to be reworked into clinical pharmacy risk - AS September 2026 and dispensary service Risk PE/JM September 2026	14/08/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	4	14/09/2026
5761	967	Physical or psychological harm	Group Chief Operating Officer	Hamer, Fiona	Smith, Charles	Care Group Governance/PRM	Workforce Strategy Group	03/03/2026	25	Medicine	Specialty Medicine CBU	Gastroenterology	Trust-wide	Risk of Patient Harm and Deteriorating IBD Outcomes Due to Insufficient IBD Clinical Nurse Specialist Workforce Capacity	As a result of establishment vacancies, absences and the gap in establishment versus GIRFT recommended WTE workforce, within the IBD Clinical Nurse Specialist team there is a risk of delays to medications management, increased non-elective admissions and delays to follow up appointments for patients with confirmed IBD. This will negatively impact patient outcomes and may result in incidences of causing harm to patients – there is an increased risk of morbidity and mortality when patients with disease that has significant impact on quality of life have delays in being seen/accessing care, primarily due to developing surgical and medical complications. This position has worsen in the coming months as the lead ACP for the service is leaving.	•Patients will be booked into Gastroenterology Consultant clinics for their follow-up appointments as soon as possible – there significant follow-up backlogs in gastroenterology consultant clinics so delays in IBD FU's are still a likely occurrence. •Nurses will focus their resources on managing the nurse-led advice line to reduce the volume of patients who present to emergency departments with a flare of their condition. •Patients advised to attend an emergency department if very unwell. -Recruitment has taken place for posts and now to include prescriber -Currently have member of staff in PSH checking on advice line and voicemails.	•Non-elective admissions for patients with IBD •Datix Incidents involving patients with confirmed IBD •Patients who are overdue their follow up appointment. •Complaints received involving patients with confirmed IBD.	Action 1: Business Unit supporting with managing the IBD MDT including the agenda and capturing outcomes. Lead: Donna Gibbins Completion date: Ongoing Action 2: Discussions are underway with Team and IT to try and manage advice line demand more automatically. Lead: Kimmi Highfield Completion date: Ongoing Action 3: IBD Nurse led clinics currently on hold with patients seen in consultant clinics when necessary. Lead: Kimmi Highfield Completion date: Ongoing Action 4: IBD Nurse in-reach service currently on hold with issues to be picked up via the gastroenterology team. Lead: Kimmi Highfield Completion date: Ongoing Action 5: Process for prescribing repeat medications, including review of the bloods, will need to be absorbed by consultant body	10/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	10/10/2026

4935	58	Service disruption	Group Chief Operating Officer	Rojas, Mrs Wendy	Chamberlain, Liz (Elizabeth)	Care Group Governance/PRM	Workforce Strategy Group	26/05/2022	16	Surgery	PACT - (Pre-assessment, Anaesthetics and Pain, Critical Care and Theatres) CBU	Critical Care		Insufficient medical staffing at ICU Lincoln and Boston	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	Recruitment to vacant posts.	25/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Within risk appetite	4	26/11/2026
4905	48	Physical or psychological harm	Group Chief Integration Officer	Cooper, Mrs Anita	Taylor, Ruth	Care Group Governance/PRM	Workforce Strategy Group	22/04/2022	12	Alliance	Therapies and Rehabilitation CBU		Trust-wide	Insufficient staffing and experience creating a risk patients will not receive assessment and rehabilitation	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.	To seek agreement to be able to recruit to maximum within allocated budgets – this was agreed in principle, however, vacancy control and financial management constraints have only achieved partial success Ruth Taylor – March 2027	17/09/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Within risk appetite	9	17/12/2026
Strategic Objective								**3a: Transform clinical pathways, rationalise our estates investing more in community care and reduce reliance on acute services**																	

5711	915	Service disruption	Group Chief Integration Officer	Rich-Mahadkar, Sameedha	Rich-Mahadkar, Sameedha			03/10/2025	20	Corporate	Integration and Improvement		Trust-wide	Risk to our transformation programme due to changes within the ICB.	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.	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 Action 5: Refresh stakeholder mapping following organisational	06/10/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	12	06/11/2026
5563	782	Physical or psychological harm	Group Chief Integration Officer	Lynch, Diane	Harding, Paul	Alliance Steering Group		19/12/2024	16	Alliance	Outpatients & Community Medicine CBU	Neurology	Trust-wide	Neurology – Service sustainability	As a result of the retirement of 50% of the substantive workforce in Apr 2025 and a challenging national recruitment environment; there is a risk that the trust's Neurology service will cease to function sustainably. This would lead to a risk of harm to patients via delayed outpatient appointments, delayed inpatient reviews and an inability of the service to meet it's demands. Prior to the impending retirement, the Neurology service is already in a situation whereby substantive capacity does not meet recurrent demands on the service At present Neurology has 5900 overdue patients on its PBWL, 44% of which (2415) are overdue by more than 1 year. At this time there is no clinical capacity (for all the reasons highlighted in this report) for any clinical validation of this backlog and no available administrative resource for a data cleanse. It may be some of these patients no longer require follow-up, are now under the care of other centres or represent	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	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.	23/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	23/10/2026

5710	916	Finances	Group Chief Integration Officer	Fradgley, Daren	Fradgley, Daren		Medicines Quality and Safety Group	01/10/2025	20	Corporate	Integration and Improvement		Trust-wide	Risk of unsuccessful delivery of transformation programme.	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.	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)	03/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	02/10/2026
5598	853	Physical or psychological harm	Group Chief Operating Officer	Marsh, David	Constantin, Dr Carmen			19/02/2025	20	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	Risk of Patient Harm Due to Insufficient Hyperacute Stroke Unit (HASU) Capacity	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	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	06/07/2026	Quite likely (4)	71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	8	06/10/2026

4778	94	Physical or psychological harm	Group Chief Integration Officer	Hamer, Fiona	Marsh, David	Patient Safety Group		16/01/2022	15	Medicine	Cardiovascular CBU	Stroke		Risk of failure to meet best practice standards for stroke patients due to lack of access to community rehabilitation service	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	Stroke pathway development project on place. Close partnership working within community to expedite discharges into the community	25/08/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Above risk appetite	6	25/11/2026
5776	987	Physical or psychological harm	Group Chief Integration Officer	Fradgley, Daren	Fradgley, Daren	Patient Safety Group		02/04/2026	25	Corporate	Integration and Improvement	Planning and Improvement	Trust-wide	Risk of delay in Improvement Programme delivery impacting quality, flow and financial performance	There is a risk that the Group will be unable to progress the opportunities identified through the diagnostic deep dive and associated improvement programmes, including the transformation of intermediate (INT) and community-based care. Failure to deliver this transformation may result in care not being provided in the most appropriate setting, leading to avoidable admissions, increased length of stay, patient deconditioning, poorer patient experience and increased risk of patient safety harm. This would adversely impact patient flow, capacity, service quality and outcomes, alongside missed opportunities for financial sustainability and delivery of the ambitions set out in the 10-year plan. The breadth of impact across patient safety, experience, system flow, service delivery and financial performance elevates this to a significant organisational risk.	Existing patient flow programme-but no real additional benefit	CIP saving target Patient flow data Complaints PALS Incident reports Discharge Dashboard	Action 1. To procure a delivery partner - second proposal to be developed for sign off by Region and ICB. Lead: Nikki PownallCompletion date: TBC	15/07/2026	Reasonably likely (3) 31-70% chance	Extreme (5)	High risk (15-16)	15	Above risk appetite	10	15/10/2026

5535	784	Physical or psychological harm	Group Chief Operating Officer	Hamer, Fiona	Constantin, Dr Carmen			07/11/2024	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	No Stroke Patient access to Clinical Psychology in line with current guidelines	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	Commission post and recruit to post, currently lies with CBU Proposal for additional ward space	25/08/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	6	25/11/2026
5745	941	Service disruption	Group Chief Integration Officer	Rivett, Kate	Coghill, Piper	Children & Young Persons (CYP) Oversight Group		21/01/2026	10	Alliance	Community Services - Community Paediatrics and Children Nursing	Community Paediatrics		Gap in service provision for ADHD patients aged between 16 and 18	As a result of the withdrawal of the ADHD 360 service and the shift in expectation that Community Paediatrics will continue ADHD care up to age 18, there is a risk that young people aged 16–18 will experience reduced access to appropriate ADHD assessment and management. This would lead to delays in treatment, unmet clinical needs, and increased pressure on paediatric clinicians managing patients with more complex social and developmental contexts. There is also a significant service disruption impact as there is reduced capacity to see other patients across all of Community Paediatrics.	Community paediatricians are continuing to support these patients on an interim basis, however this is contributing to a worsening of the service disruption to other patient cohorts.	Incident reporting Monitoring of patient discharge ages	Pursue contract discussions with the ICB to ensure appropriate funding and governance arrangements are in place for ULTH to continue providing this service. If this is unsuccessful, identify and implement a plan to safely stop providing this service and restart the discharge of patients to their GP at 16.	21/08/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	6	20/11/2026

5169	60	Physical or psychological harm	Group Chief Operating Officer	Marsh, David	Constantin, Dr Carmen	Patient Safety Group		09/05/2023	15	Medicine	Cardiovascular CBU	Stroke	Lincoln County Hospital	Delay in stroke rehab therapy for stroke outlier patients.	As a result of consolidating the acute stroke services at one site without appropriate stroke therapy staffing & bed base, many stroke inpatients reside outside the stroke unit as outliers and do not receiving the adequate level of therapy input in line with guidelines and patient-centred care, the effect is increased risk of mortality and long term disability, as well as low staff morale and poor staff retention. There is a risk of an increase of delays to patient care, causing harm and reduced functional outcomes/recovery for stroke patients. Current mitigations mean patients on the Stroke Unit may also receive less therapy input in an attempt to deliver some input to outliers.	Stroke Therapy Team review all outliers at the cost of not seeing the Stroke ward patients as much. Stroke team will advise general ward based therapy team. Minimal basic Stroke assessment and treatment skills for general ward therapy staff. Proposal to implement Trusted Assessor Stroke Assessment. Cohort some outlier A Consultant AHP has been recruited to provide leadership and stroke pathway oversight needed across the group	SSNAP data Datix Complaints Staff retention & post vacancy	1) Recruit stroke therapists [PT/OT/SALT/Dietician] consistent with current service demands in line with guidelines - Ruth Taylor - December 2025 2) Expand Stroke bed base with funded therapy posts in line with Stroke Guidelines to reduce risk, reduce length of stay and deliver the 'centre of excellence' the population of Lincolnshire were promised - Ruth Taylor - June 2027-due to building work. 3) Refurbishment and workforce development – business case to be submitted - Rebecca Johnson - March 2026	25/08/2026	Extremely likely (5) >90% chance	Moderate (3)	High risk (15-16)	15	Above risk appetite	3	25/11/2026
Strategic Objective									**3c (i) Enhance our digital capability through innovation delivering the 10 year health plan**																				
5812	1007	Service disruption	Group Chief Integration Officer	Creasey, Stephen	Creasey, Stephen			08/07/2026	20	Corporate	Integration and Improvement	Digital Services (ICT)		Board Assurance Framework Over Arching Cyber Risk	As a result of failure in preventing a successful cyber-attack, there is risk that a successful event is likely to cause detrimental impact to the delivery of care and related corporate services, resulting in patient harm, operational disruption, data loss, financial implications, and reputational damage for the Trust and partners in the Lincolnshire ICS.	Please refer to the list of identified risk as detailed in the Risk supportive information section. Each risk will have updates associated with any gaps in cyber or information security base line controls which for ULTH and Lincs ICS partner are aligned with the DSPT CAF standards. Appointed a named executive to own and coordinate cyber risk Dedicated cyber risk on the Board Assurance Framework Agreed a cyber risk appetite and operational tolerances at RRC+C 15/07/2026	Measured through a combination of cyber control KPIs and empirical evidence such as actual breaches and identified impacts suffered by other organisations of similar and greater size. Additionally, regular threat intelligence updates indicate new vulnerability, how exposure is exploited, and what associated threat actor appetite is driving the focus e.g. on the healthcare sector.	Action 1. Understand the organisation's cyber risk and what it means in practice with respect to the impact on essential functions (critical clinical, operational, digital and supplier-provided services). Lead: Group Chief Completion date: 01 Sep 2026 Action 2. Identify the systems and services most critical to safe care and continuity, and agree recovery priorities, with update/assurance to Finance and Performance Committee. Lead: Deputy Director Digital/Head of Application Services.Completion date: 31 Dec 2026 Action 3. Test cyber preparedness through walkthroughs and tabletop exercises, involving executive, clinical, operational, digital, communications, emergency planning and risk teams. (A program of events through each DSPT year). With reporting to FPC and FPG	23/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	8	23/10/2026

5519	739	Regulatory compliance	Group Chief Integration Officer	Fradgley, Daren	Evans, Thomas	DIG		08/10/2024	16	Corporate	Integration and Improvement	Digital Clinical Safety Services	Trust-wide	Risk of the unsafe deployment of Health IT Systems at ULTH	As a result of the lack of an established Digital Clinical Risk Management system (Health IT system), processes and resource resulting in non-compliance with the Digital Clinical Safety Standards DCB0129 and DCB0160 (the Standards mandated by NHSE to ensure the safe manufacture, development, deployment, and use of Health IT Systems) this could lead to patient safety incidents involving digital systems, resulting in or contributing to patient harm or death. An informal 'best endeavours' approach has previously been taken and digital clinical systems have been deployed that have not fully met the Standards. The Standards also mandate an approach to Clinical Risk Management which continues for the entire lifecycle of the Health IT system, not just prior to initial deployment. Under the standards, the CRMS must have proactive and reactive elements to effectively manage post deployment patient safety	•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	•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	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	01/09/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Within risk appetite	12	08/10/2026
4641	18	Service disruption	Group Chief Integration Officer	Fradgley, Daren	Ryan, Paul	DIG	Emergency Planning Group	23/11/2021	16	Corporate	Integration and Improvement	Digital Services (ICT)	Trust-wide	Digital infrastructure disruption	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	- 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.	15/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Within risk appetite	4	15/10/2026
Strategic Objective									**3c (ii) Enhance our digital capability through delivery of our EPR in 2026/27/28**																				

4731	33	Physical or psychological harm	Group Chief Integration Officer	Humber, Michael	Humber, Michael	Digital Oversight Group	Information Governance Group, Patient Safety Group	13/01/2022	20	Corporate	Integration and Improvement	Digital Services (ICT)		Reliance on paper medical records	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.	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.	17/09/2026	Extremely likely (5) >90% chance	Severe (4)	Very high risk (20-25)	20	Above risk appetite	4	15/10/2026
5648	870	Physical or psychological harm	Group Chief Integration Officer	Fradgley, Daren	Humber, Michael			25/04/2025	20	Corporate	Integration and Improvement		Trust-wide	Risk of paper based records and stand alone digital systems	The Trust is currently carrying a significant number of risks associated with the reliance on paper-based health records (covered by Datix risk ID 4731) and legacy stand-alone digital systems. There is currently an inability to deliver the required level of patient safety that is enabled by technology and innovation, via more robust and consistent clinician decision making and access to the right information in the right place at the right time. Without an integrated Electronic Patient Record (EPR) and Electronic Document Management System (EDMS) the Trust risks not achieving the key benefits outlined in the EPR Full Business Case (FBC). There is clear evidence in the FBC that an EPR can deliver significant benefits to an organisation which may be unrealistic to deliver with (paper-based systems and) stand-alone digital health systems. These include: •Providing accurate, up-to-date, and complete information about	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.	The implementation of an integrated EPR and EDMS systems, predominantly funded by the national Frontline Digitisation Programme.	15/07/2026	Quite likely (4) 71-90% chance	Severe (4)	High risk (15-16)	16	Within risk appetite	8	15/10/2026

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.

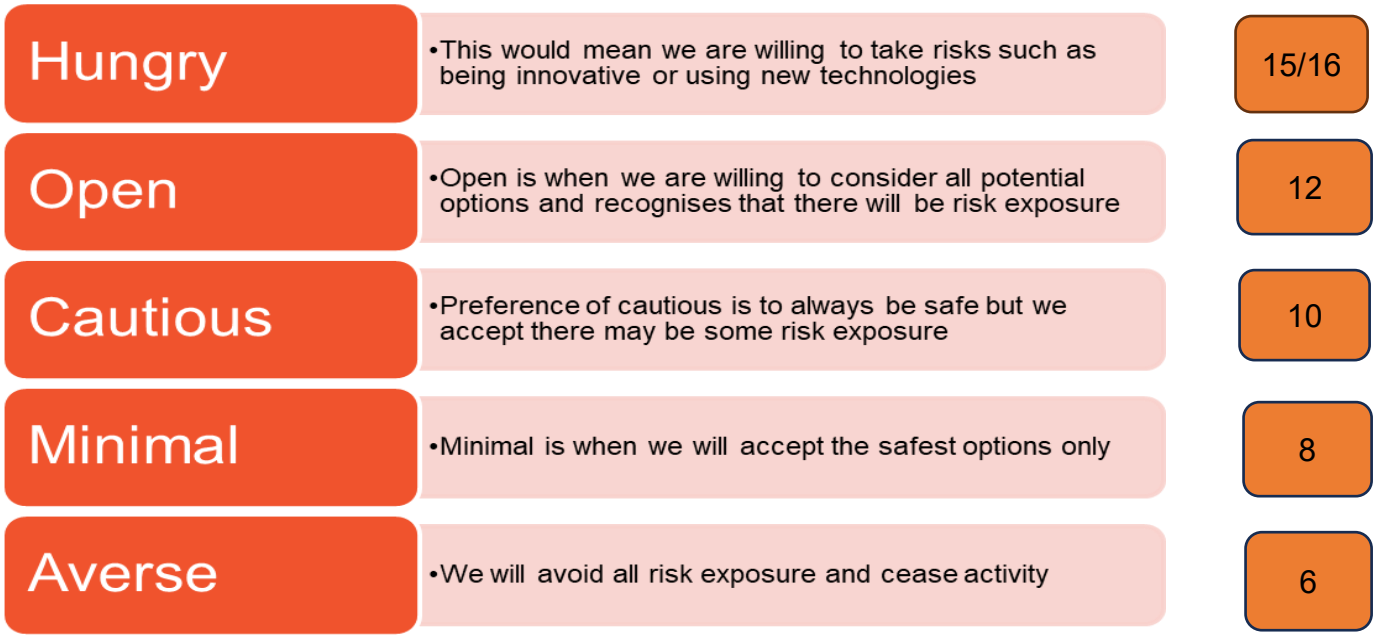


Table 2 details each strategic objective, along with associated risk appetite level and risk appetite statement. The upper tolerance level shown represents the maximum risk tolerance for each objective and provides guidance for risk owners to use in managing their risks.

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 resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	**12**

1a (iii) Clinically Effective Care	**Open**	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny.	**12**
1b	**Open / Cautious**	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm in all care settings	**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. 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**
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 foster a strong, inclusive and enabling culture that empowers our people to continuously improve and innovate, they will feel unable to perform their roles effectively and take ownership of change. This will limit our ability to deliver the required transformation in the quality, efficiency and effectiveness of our services, resulting in a disengaged and disenfranchised workforce, poorer clinical outcomes and diminished patient experience.	**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 listen to the needs and wants for our communities and deliver an aligned approach in collaboration with our partners, we will continue to duplicate care and deliver inefficient outcomes	**12***

***New Strategic Objective – appetite to be confirmed**

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 NHS Group Board*
Date of meeting	*3 November 2026*
Agenda item number	*12.2*
Report title	*Group Board Assurance Framework*
Report purpose: • Discussion • Approval • Assurance • Information • Other – please insert details	• *Assurance* • *Approval*
Accountable Director	*Jayne Warner, Group Director of Corporate Affairs*
Author(s)	*Karen Willey, Deputy Trust Secretary, ULTH*
Assurance rating: • Substantial assurance • Reasonable assurance • Limited or no assurance	• *Substantial assurance*
Prior approval process, if applicable	*Considered through board committees*
Financial implications, if applicable	*N/A*
Action / decision required	The Group Board is asked to: • note the updated BAF for 2026/27 including final risk scores & assurance ratings; • review progress with the completion of actions to address gaps in controls and assurances; • 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 whilst addressing our requirements for sustainability and our Green agenda	*X*
People: Better Opportunities – Develop, empower and retain great people:	
2a: Enable our people to fulfil their potential through high quality training, development and education, underpinned by a positive and inclusive culture	*X*
2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	*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 (i): Enhance our digital capability through innovation delivering the 10 year health plan	*X*
3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28	*X*
3c (iii): Enhance our research and innovation capability linked to our population health needs	*X*
3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	*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.

Each of the board committees review, challenge and seek assurance in respect of the areas of the BAF for which they have oversight on a monthly basis with escalation, as required, to the Group Board.

Summary of the Report

This report provides the final, updated BAF for the 2026/27 year following the agreement by the Board in May 2026 of refreshed strategic objectives and following substantial updating in conjunction with executive leads and their teams.

The BAF has been reviewed by the board committees during October 2026 and agreed changes have been incorporated in the final, updated version for which there are no proposed changes to risk or assurance ratings.

The BAF has also been considered by the Audit Committee during October 2026 where it was confirmed that the format remains relevant and effective for the Group as well as concentrating on the right high risks.

Group Board Action Required

The Group Board is asked to:

- note the updated BAF for 2026/27 including final risk scores & assurance ratings;
- review progress with the completion of actions to address gaps in controls and assurances;
- agree the need for any additional action or assurance at this stage.

Lincolnshire Community & Hospitals NHS Group (LCHG)

Group Board Assurance Framework (BAF)

As at October 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 in all care settings
	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 whilst addressing our requirements for sustainability and our Green agenda	If we do not **effectively maintain our estates**, in line with mandatory & statutory requirements and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny. If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in services becoming unsustainable
People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture	If we do not **foster a positive and inclusive culture that supports high-quality training, development and education**, our people will be unable to fulfil their potential or support the delivery of new models of care, leading to reduced quality, increased risk of avoidable harm, inefficiency and challenges in attracting and retaining staff.
	2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	If we do not **foster a strong, inclusive and enabling culture that empowers our people to continuously improve and innovate,** they will feel unable to perform their roles effectively and take ownership of change. This will limit our ability to deliver the required transformation in the quality, efficiency and effectiveness of our services, resulting in a disengaged and disenfranchised workforce, poorer clinical outcomes and diminished patient experience.
	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: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	If we do not listen to the needs and wants for our communities and **deliver an aligned approach in collaboration with our partners**, we will continue to duplicate care and deliver inefficient outcomes

Group BAF: Position Overview as at October 2026

Strategic Aim	Strategic Objective	Strategic Risk	Executive Lead(s)	Board Committee Oversight	Current Risk Score (as at October 2026)	Target Risk Score (March 2027)	Assurance Rating (as at October 2026)	Target Assurance Rating (March 2027)
Patients: Better Care – Timely affordable, high quality care in the right place	1a (i): **Improve patient safety**, patient experience and deliver clinically effective care	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny	Group Chief Nursing Officer / Group Chief Medical Officer	Quality Committee	**8 (Moderate)**	**3 (Very Low)**	**Amber**	**Green**
	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care				**9 (Moderate)**	**4 (Low)**	**Amber**	**Green**
	1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**				**8 (Moderate)**	**3 (Very Low)**	**Amber**	**Green**
	1b (i): Reduce waiting times for our patients **(Unplanned Care)**	If we do not improve the efficiency and effectiveness of our services then we will not **improve access and flow** resulting in patients waiting too long for treatment, poorer clinical outcomes and increased risk of clinical harm in all care settings	Group Chief Operating Officer / Group Chief Integration Officer	Finance & Performance Committee	**15 (High)**	**10 (Moderate)**	**Amber**	**Green**
	1b (ii): Reduce waiting times for our patients **(Planned Care)**				**15 (High)**	**10 (Moderate)**	**Amber**	**Green**
	1b (iii): Reduce waiting times for our patients **(Out of hospital)**				**10 (Moderate)**	**5 (Low)**	**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	**16 (High)**	**8 (Moderate)**	**Amber**	**Green**
	1d: Provide modern, clean and fit for purpose care settings whilst addressing our requirements for sustainability and our Green agenda	If we do not **effectively maintain our estates**, in line with mandatory & statutory requirements and we do not continue to invest in our estates including through securing alternative sources of capital funding, we will not achieve our objectives or transforming clinical pathways and improving patient safety, patient experience and delivering clinically effective care resulting in increased regulatory / system scrutiny. If we do not drive forward our Green Plan we will be unable to effectively transform key clinical pathways and **reduce our carbon footprint** resulting in	Group Director of Estates & Facilities	Finance & Performance Committee	**16 (High)**	**12 (High)**	**Amber**	**Amber**

		services becoming unsustainable						
People: Better Opportunities – Develop, empower and retain great people	2a: Enable our people to fulfil their potential through high-quality training, development and education, underpinned by a positive and inclusive culture	If we do not **foster a positive and inclusive culture that supports high-quality training, development and education,** our people will be unable to fulfil their potential or support the delivery of new models of care, leading to reduced quality, increased risk of avoidable harm, inefficiency and challenges in attracting and retaining staff.	Group Chief People Officer	People Committee	**6 (Low)**	**6 (Low)**	**Green**	**Green**
	2b: Create a culture that empowers our people to deliver change through continuous improvement and innovation	If we do not **foster a strong, inclusive and enabling culture that empowers our people to continuously improve and innovate**, they will feel unable to perform their roles effectively and take ownership of change. This will limit our ability to deliver the required transformation in the quality, efficiency and effectiveness of our services, resulting in a disengaged and disenfranchised workforce, poorer clinical outcomes and diminished patient experience.	Group Chief People Officer	People Committee	**9 (Moderate)**	**6 (Low)**	**Amber**	**Green**
	2c: Nurture compassionate and diverse leadership	If we do 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	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	**6 (Low)**	**3 (Very Low)**	**Green**	**Green**

	3b: Move from prescription to prevention, through a population health management & health inequalities approach	If we do not change to a more innovative approach to tackling health inequalities in collaboration with system partners then we will be unable to effectively discharge our responsibilities for **improving population health** resulting in less equitable access to services and poorer clinical outcomes	Group Chief Integration Officer	Integration Committee	**6 (Low)**	**6 (Low)**	**Green**	**Green**
	3c (i) Enhance our digital capability through innovation delivering the 10 year health plan	If we do not **enhance our digital, Innovation** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3c (ii) Enhance our digital capability through delivery of our EPR in 26/27/28	If we do not **enhance our digital care models through EPR** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3c (iii) Enhance our research and innovation capability linked to our population health needs	If we do not **enhance our research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale	Group Chief Integration Officer	Integration Committee	**12 (Moderate)**	**8 (Moderate)**	**Amber**	**Green**
	3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities	If we do not listen to the needs and wants for our communities and deliver an aligned approach in collaboration with our partners, we will continue to duplicate care and deliver inefficient outcomes	Group Chief Integration Officer	Integration Committee	**6 (Low)**	**6 (Low)**	**Green**	**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:	October 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	Aug-26	4	2	8 (Moderate)	Amber
Target	Mar-27	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

	Identified Controls *(What are we already doing to manage the risk?)*
1	Quality & safety priorities and KPIs agreed but continually under review as new areas of concern are identified
2	Safety culture approach established with an action plan agreed which is being rolled out
3	Patient Safety Partners appointed and human factors guidance & training in place
4	Clinical Governance Framework, teams & structures in place and refined to reflect the move to group with in-reached support provided to Care Groups
5	Strong PSIRF process in place & learning from incidents processes well embedded
6	Strong focus on maternity & neonatal safety
7	Improvement plans in place to address identified risks e.g. management & use of medical devices, medicines safety, wound care management, effective practice & harm free care
8	Ward / service accreditation process in place
9	IPC team and continually evolving IPC governance framework in place to prevent, detect and manage infection risks across all settings within the group
10	Safeguarding team and governance framework in place across the group
11	Robust Patient Safety Alert System with oversight and reporting in place
12	Structured learning framework in place supported by triangulation of multiple sources of evidence and aligned to local and national expectations
13	Care Group governance arrangements in place
14	Datix system and processes in place
15	Robust oversight and escalation processes in place for policies, procedures and guideline development. Improvement trajectory agreed for 2026/27 for bringing overdue policies, procedures and guidelines back into compliance with quarterly reporting to relevant board committees

	Gaps in Controls *(What are the gaps in control that are required to manage the risk)*
1	None identified
2	None identified
3	None identified
4	None identified but see 13. below.
5	Action plans are not always robust and / or are not tested for effectiveness / impact
6	None identified
7	None identified
8	Ward / service accreditation programme not fully embedded in community
9	LCHS and ULTH are not fully compliant with all standards within the IPC BAF with ongoing issues in some areas with adherence to fundamentals / basic principles
10	There continues to be low uptake of mandatory safeguarding training by some operational teams & staff groups (e.g. medical staff) and lack of medical engagement in some safeguarding processes
11	None identified
12	Learning approach developed and rolled out but needs embedding across the group.
13	A review of the clinical governance arrangements within Care Groups is being undertaken to ensure these arrangements are aligned and remain robust across the group
14	There is a need to move to a single Datix System
15	There is a need to identify a robust long-term solution for the management of document control to ensure sustainability of the required improvements

	Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*	Executive Lead	Operational Lead	Due Date	Progress
5	Strengthen oversight and sign off process for actions being reviewed with the Patient Safety Team to ensure SMART actions are taken	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	Ongoing	Process commenced and reviewed as part of the PSIRF processes with internal QA embedded
8	Continue to embed the ward / service accreditation programme within community	Group Chief Nurse	Group Deputy Chief Nurse	31 March 2027	Review of plan to agree necessary resources, leadership, staff development and priorities to take forward. Programme established for community hospitals, community nursing and OPDs with monthly quality dashboards in place. Unannounced peer review visit programme commenced. Phase 2 work is underway to continue to expand and rollout to additional services during Q3/4. UTCs piloting quality assurance tool.
9	Continue to progress the mitigating actions for the areas of non-compliance with the IPC BAF. Continue to promote awareness of IPC practice / fundamentals with a specific programme of work targeting medical staff and the prevention and reduction of *C. difficile* infection via a restoration and recovery plan and inclusion on the Trust Risk Register	Group Chief Nurse	Deputy Director of Infection Prevention and Control	Ongoing	Ongoing
10	Continue to work with Care Groups and Group Chief Medical Officer to increase levels of compliance with mandatory safeguarding training and improve medical leadership and engagement with safeguarding processes	Group Chief Nurse	Group Director of Safeguarding & Patient Experience	April 2027	Monthly reported continues to be monitored and escalated to Care Groups and Medical Director
12	Continue to embed the learning framework across the group	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	Ongoing	As per the learning framework, embedding into practice will be evidenced by translation into local action plans, strengthened feedback loops through the governance framework, integration into simulation, and education & leadership development evidenced by quality improvement
13	Complete the review of Care Group clinical governance arrangements	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	30 September 2026	Underway – Clinical Governance Framework to be launched at GLT on 21 August 2026 with implementation starting from 1 September 2026 Update 08/09/26 – due to the cancellation of the 21 August 2026 GLT the implementation date has been pushed back until the 18 September 2026. Update 08/10/26 – Clinical Governance Framework now launched at GLT – team now working with the Care Groups to embed the proposed changes over the next 6 months to standardize and strengthen the process.

14	Move to a single incident management system	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	30 June 2027	The current Datix Licences for both Trusts are due to expire at the end of March 2027. Work has commenced on the move to a single incident management system: contract specification to be issued early August 2026 with a view to a new supplier being identified by the end of December 2026. Changes will be enacted between January – March 2027 with 'Go Live' from 1 April 2027
15	Identify a robust long-term solution for the management of document control	Group Chief Clinical Governance Officer / Group Director of Corporate Affairs	Group Deputy Chief Clinical Governance Officer / Patient Safety Specialist	31 March 2027	Underway

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	Medical Devices Group in place reporting to the Patient Safety Group
10	Fully established governance structure reporting into the Quality Committee in place with clear escalation routes and routine upward reporting. Sub-groups in place reporting to the Patient Safety Group (e.g. IPC / Skin Integrity / Care Groups etc.)

Gaps in Assurance	
1	The Patient Safety Group continues to have a large remit and agenda. There is a need for increased medical engagement in Patient Safety Group meetings
2	None identified
3	None identified
4	None identified
5	None identified
6	None identified
7	A review of reporting into MNOG is currently being undertaken to ensure this remains robust and captures all key requirements
8	None identified
9	None identified
10	Sub-groups reporting into the Patient Safety Group have been aligned however the 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**
1a	The remit and agendas of the Patient Safety Group should remain under review to ensure its ongoing effectiveness	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	31 March 2027	To be formally reviewed as part of the annual review of effectiveness

1b	Continue to encourage medical engagement in Patient Safety Group meetings	Group Chief Medical Officer	Group Deputy Chief Medical Officer	Ongoing	Ongoing – The Deputy Medical Director now attends Patient Safety Group meetings. The new Chief Registrar will also attend once in post. Further discussion is required to capture resident doctor attendance
7	Complete the review of reporting into MNOG	Group Chief Nurse	Director of Midwifery	30 September 2026	Underway – 'deep dive' held on Monday, 13 July 2026
10	Continue to develop and embed the sub-groups reporting into the Patient Safety Group	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	Ongoing	Ongoing

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	4746	20	Overdue patients on Ophthalmology PBWL
ULTH	4855	20	Delayed diagnosis of breast cancer
ULTH	5800	20	Delayed issue of clinic letters due to clinical typing backlog
ULTH	5795	20	Lack of Consultant staffing for Orthodontic service

Related risks on Risk Register – LCHS

Trust	Datix ID	Score	Summary Risk description
LCHS	849	20	Risk of school aged children not receiving timely SLT

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (ii): **Improve** patient safety, **patient experience** and deliver clinically effective care
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

9 (Moderate)

⇔

Last Review Date:	August 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	Aug-26	3	3	9 (Moderate)	Amber
Target	Mar-27	2	2	4 (Low)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	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 renewed and agreed at the Patient Experience & Involvement Group
2	Patient Experience & Involvement Team and processes in place
3	Group approach to Patient Panels agreed and in place
4	Established complaints & PALS teams and processes in place
5	Group Complaints & PALS Policy agreed to embed learning
6	Improvement plans developed in response to national patient experience surveys
7	PLACE reviews completed and improvement plans developed in response to findings
8	Systems in place for reporting on patient experience and volunteer statistics

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	None identified
2	None identified
3	None identified
4	None identified
5	None identified
6	Lack of staff engagement has the potential to lead to a lack of timely implementation of improvement plans
7	PLACE improvement plans developed but not fully implemented
8	The capturing of diversity information from patient feedback and voluntary services is not robust however will improve with the launch of the new Friends & Family Test

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Review and refresh the patient experience KPIs	Group Chief Nurse	Group Head of Patient experience and Volunteer Services	31 August 2026	Completed
6	Mainstream co-production to engage staff in service development and patient centred care	Group Chief Nurse	Group Head of Patient experience and Volunteer Services Head of Patient Experience / Care Groups	31 December 2026	Ongoing
7	PLACE improvement plans to be finalised	Group Chief Nurse	Group Head of Patient experience and Volunteer Services Head of Patient Experience / Care Groups	31 August 2026	Ongoing
8	Increase engagement with local groups	Group Chief Nurse	Group Head of Patient experience and Volunteer Services Head of Patient Experience	31 August 2026	Underway: development of the group patient engagement framework is continuing in partnership with communications and engagement colleagues, aligning with the emerging Group Communications and Engagement Strategy. Work is also continuing with system partners and the ICB engagement lead to strengthen coordinated engagement with seldom heard groups, reduce duplication of requests and improve oversight of patient and community involvement routes across the group

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of patient experience and key risks by the Quality Committee and its reporting sub-group: the Patient Experience & Involvement Group, with escalation to the Group Board as required
2	Reporting on quality & safety and patient experience KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
3	Patient Stories are heard routinely at the Group Board
4	Patient experience data is gathered and improvements tracked through the Patient Experience & Involvement Group
5	Internal and external audit, patient surveys, PLACE review etc. provide independent assurance on the quality of the patient experience
6	Sub-groups in place reporting to the Patient Experience & Involvement Group

Gaps in Assurance	
1	None identified
2	There is no routine reporting of patient experience at Care Group level
3	None identified
4	None identified
5	None identified
6	Sub-groups reporting into the Patient Experience & Involvement Group have been aligned however the 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
2	Introduce routine reporting of patient experience data within Care Group Triumvirate meetings	Group Chief Nurse	Group Head of Patient experience and Volunteer Services Head of Patient Experience / Care Groups	31 December 2026	Data Spread Sheets Being Developed ~~Underway~~
6	Continue to develop and embed the sub-groups reporting into the Patient Experience & Involvement Group	Group Chief Nurse	Group Head of Patient experience and Volunteer Services Head of Patient Experience	December 2026	Ongoing

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1a (iii): Improve patient safety, patient experience and **deliver clinically effective care**
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not develop a strong safety culture that supports learning, innovation and best practice, we will not **deliver safe, effective and responsive care** to our patients resulting in increases in avoidable harm & mortality, poor clinical outcomes & patient experience and increased regulatory / system scrutiny

Current Risk Score & Movement since last review:

8 (Moderate)



Last Review Date:	October 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	Aug-26	4	2	8 (Moderate)	Amber
Target	Mar-27	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	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 with escalation processes for non-compliance agreed
3	NICE Policy and process in place with escalation processes for non-compliance agreed
4	Medical Examiner Service in operation and well established
5	Mortality review process in place and learning from deaths process well established with escalation processes for non-compliance agreed
6	Safety concerns and / or learning is disseminated to Care Groups and specialty governance
7	Getting It Right First Time (GIRFT) Programmes of work in place
8	National audit processes are in place to monitor performance and provide assurance

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	None identified
2	None identified
3	None identified
4	None identified
5	Coding issues remain a contributory factor driven by poor documentation where outliers are identified from 'deep dives' (e.g. GI bleed)
6	Actions translated from learning are not always reviewed for effectiveness / impact
7	A revised GIRFT governance process has been implemented; however, there is currently no evidence available to demonstrate its effectiveness or assure compliance with the intended oversight and reporting arrangements.
8	A number of outliers have been identified through national audits, indicating areas of performance variation requiring improvement

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
5	Coding masterclasses to be provided and documentation gaps to be addressed as parr of the EPR programme	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	Ongoing	Coding masterclasses are in place and held quarterly
6	Continue to ensure that actions arising from safety learning are documented, assigned, monitored through governane structures and subject to effectiveness reviews with evidence of impact prior to closure	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	31 December 2026	Action tracker developed and implemented to record all actions arising from safety learning. Actions are assigned to named leads and monitored through Care Group and specialty governance meetings. A process for reviewing and evidencing effectiveness and impact prior to closure has been established and is being embedded across services
7	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 2027	Underway – a proposed GIFRT governance structure has been developed and presented. Further work is underway to finalise roles, responsibilities, reporting arrangements, and oversight mechanisms to support effective governance of GIRFT programmes. A dedicated GIRFT Lead has been recruited within the PMO team. Work is underway to strengthen data utilisation and Best Practice reviews. Enhanced oversight arrangements are being implemented to ensure Care Groups provide assurance on actions being taken from GIRFT and Best Practice findings, with all actions tracked through Monday.com to provide transparency, accountability and reporting to CEG
8	Strengthen Care Group ownership of national audit performance through routine monitoring of audit data, enabling early identification of non-compliance and proactive development and oversight of improvement actions	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	31 March 2027	Audit Facilitators are ensuring national audit results are routinely presented through governance forums. Care Groups are responsible for developing and monitoring improvement actions and providing upward reporting on performance and progress to the Clinical Effectiveness Group

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	Sub-groups reporting into the Clinical Effectiveness Group in place (e.g. HTA / MOG / Care Groups etc.)
3	Reporting on quality & safety and clinical effectiveness KPIs to the Quality Committee and Group Board through the Integrated Performance Report (IPR)
4	Learning from deaths reported to the Clinical Effectiveness Group and disseminated across the group
5	There is regular benchmarking of mortality through the monthly reporting of the HSMR and SHMI datasets
6	There is oversight of delivery of the clinical audit programme through the Clinical Effectiveness Group with reporting to the Quality Committee as required including areas where an outlier status is received.
7	There is oversight of compliance with NICE guidance through the Clinical Effectiveness Group with escalation to the Quality Committee as required
8	Delivery of clinical effectiveness KPIs and relevant improvement plans is monitored through PRMs with Quality Committee oversight
9	Internal & external audit, external reviews and visits provide independent assurance on the robustness of the group's clinical effectiveness
10	There is system Oversight of clinical effectiveness

Gaps in Assurance	
1	None identified
2	None identified
3	None identified
4	None identified
5	None identified
6	The quality of data submitted from Care Groups often leads to outlier alerts
7	None identified
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
6	Different way of submitting data for national audits to be explored: The Patient Services Hub may offer a solution	Group Chief Clinical Governance Officer	Group Deputy Chief Clinical Governance Officer	31 March 2027	Review of current data collection processes, including the number of data clerks and ownership of data submission, is underway

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high-quality care in the right place
Strategic Objective:	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 in all care settings

Current Risk Score & Movement since last review:

15 (High)



Last Review Date:	October 2026
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	5	3	15 (High)	Amber
Target	Mar-27	5	2	10 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	High	High	High	High	High	High	High					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	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	Full Capacity Protocol (including SDEC) updated and in place. EPIC / NIC roles embedded
3	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
4	Group Discharge Board in place with a focus on discharge & flow, SAFER principles and criterial-led discharge
5	Unplanned Care Group established to drive delivery of agreed performance & improvements
6	System Unplanned Care Partnership Board in place to have oversight of system issues and challenges and to drive delivery of agreed improvements
7	OPEL escalation triggers in place and activated as required
8	Winter Plan in place
9	45-minute ambulance handover protocol agreed and enacted and delivered consistently
10	Power BI and daily validation: 111 CAS call back times, Ops Centre performance, UCR 2-hour performance, UTC 33 national standards including waiting times and booked appointments and referral to ED rate
11	Better Flow, Better Care programme established to support improvements in flow and reduction in the number of days patients are away from home.

	Gaps in Controls *(What are the gaps in control that are required to manage the risk)*
1	ED streaming allocation is now aligned to national GIRTH methodology. Digital solution not yet in place but on track for 'go live' on 26 July 2026
2	None identified
3	Daily system meetings require review with a focus on action & support
4	Time of day discharge needs improving. Work being undertaken supported by Newtons will assist with overall flow and time of day discharge
5	Assessment chair capacity not substantively funded
6	SDEC utilisation has increased however opto will further enhance SDEC take and decrease activity currently going to ED
7	None identified. Previous gap articulated was around Community OPEL 4 actions not being in place and embedded. However, OPEL 4 actions are now clearly detailed within the LCHS surge and escalation plan and will be enacted as required during periods of surge and OPEL 4 declaration.
8	There is inconsistent adherence to IP standards
9	None identified
10	Alignment of systems is required to ensure timely and accurate reporting of community data to all stakeholders – refer to Out of Hospital 1b (iii)

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	Introduce digital streaming	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 July 2026	Underway & on track
3	Undertake a review of the UEC daily system meeting Terms of Reference: request currently with new ICB cluster who have acknowledged that this review is needed	Group Chief Operating Officer	Group Deputy Chief Operating Officer	TBC	TBC
4	Implement dedicated discharge programme (P0/1/2/3) with support from Newtons: first three months of mobiliation to focus on daily operational grip and oversight of flow across the group and into the wider system	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 March 2027	Better Flow, Better Care Programme (BFBC) established and has moved from initial design and diagnostic activity into detailed design and testing, with September focused on three priority areas: ward processes, Transfer of Care Hub (TOCH) processes and intermediate care flow. October is focused on delivery of a sprint phase to deliver maximum impact and agreed benefits realisation ahead of the winter period. This includes focus on front door, ToC hub processes, Ward processes, P2 pathway development and operational management
5	Actions being taken TBC	TBC	TBC	TBC	TBC
8	Complete the rewrite of the UEC pathways and reinforce requirement for adherence to relevant standards by all specialties	Group Chief Operating Officer	Group Deputy Chief Operating Officer	TBC	Underway and on track

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Live performance dashboard in place in ED
2	ED activity, flow and LoS regularly reviewed by site teams and issues escalated through the daily capacity meetings. (In addition, daily ED assurance meetings – to discuss previous days and overnight activity and performance – held where dips in performance occur)
3	Improvement trajectories in respect of ED performance and expectations agreed for all specialties. Sustained improvements seen across the UEC pathway: standard exceeded (4 hour and 12 hour performance metrics) since March 2026 despite continued increase in activity
4	Suite of metrics in place to measure improvements and focus Care Group leadership teams on discharge target
5	Optica discharge tool implemented across the acute sites. Improvement and Digital teams supporting improved utilisation. System partners also using Optica to manage their transfer of care pathways. Optica reporting allows a weekly audit of delays using national discharge codes to understand capacity constraints and explore mitigations
6	ED performance monitored through the Unplanned Care Group and System Unplanned Care Partnership Board
7	Delivery of ED performance and improvements reviewed through the Care Group PRMs
8	Group senior supported flow team in place reporting through the unplanned care group. Oversight of all performance metrics within community PRMs and flow and TOC steering group through to ASG
9	Reporting on ED performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board as required
10	Better Flow Better Care programme reporting on progress into an Executive Steering Group, as well as routine reporting into existing governance. This is where evidence of impact and benefits realisation will be assured.

Gaps in Assurance	
1	None identified
2	None identified
3	None identified
4	Continue to strengthen oversight of performance on discharge target based on actuals rather than previous thresholds
5	Careflow and WebV timeliness of updates into Optica linked to EPR launch
6	None identified
7	None identified
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
4	Capacity redesign, building on the winter mitigation schemes, to be scoped for full delivery across 26/27 including use of CAS as safety net to all patients discharged on a supported pathway	Group Chief Integration Officer	Group Deputy Chief integration officer	TBC	The transformation of Intermediate care services including those funded via the BCF discharge fund and delivered by the group are a key workstream within the Better Flow Better care programme. This will ensure that any improvement work as a result of early pilots will be rolled out quickly, supporting winter, Additionally, the Community Connector provision has been retained
5	Working with NHS England support to run command and control for the Go Live period to identify any data feed delays into optica.	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 October 2026	2 days booked with NHS E for GoLive supported by digital team in ULTH and NHS E FDP partners

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 in all care settings

Current Risk Score & Movement since last review:

15 (High)

⇔

Last Review Date:	October 2026
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	5	3	15 (High)	Amber
Target	Mar-27	5	2	10 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	High	High	High	High	High	High	High					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Patient Services Hub in place and operational providing centralised scheduling and booking
2	Weekly PTL / activity meetings in place
3	Weekly 6/4/2 meetings held and processes in place to support theatre and OPD utilisation
4	Booking 'protocol' in place through Patient Services Hub
5	Planned Care Group established to drive delivery of agreed planned care performance & improvements
6	Forecast performance in place and used to monitor delivery
7	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	Arrangements still being embedded. Implementation of the Patient Services Hub has identified a backlog of clinic letters
2	The approach to validation remains inconsistent. Internal validation team recruited
3	None identified
4	There is no shadow booking process in place
5	Workforce gaps and gaps in job planned activity for admitted and non-admitted activity are risks for 2026/27. Time to first appointment and delivery of cancer 62-day performance are also risks for 2026/27
6	Delivery of DM01 is currently off track (U/S, MRI, Audiology)
7	There is limited financial support for the 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
1a	Continue to maximise theatres & out-patient improvements and efficiencies through the embedding of the Patient Services Hub	Group Chief Operating Officer	Deputy Group Chief Operating Officer	30 September 2026	Underway
1b	Address the backlog of clinical letters – plan in place to resolve	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 October 2026	Underway
2	National validation initiative commenced	Group Chief Operating Officer	Deputy Group Chief Operating Officer	Ongoing	Underway
4	Shadow booking process to be introduced as PSH embeds further	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 March 2027	Underway
5	Recovery plan for cancer 62-day performance in place. PSH booking to six weeks ahead improving to address time to first appointment	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 March 2027	Underway
6	Recovery Plan in place and currently on track – to be monitored throughout the year	Group Chief Operating Officer	Deputy Group Chief Operating Officer	31 March 2027	Underway
7	Discussions to remain ongoing through the Community Management Partnership Board	Group Chief Integration Officer	Deputy Group Chief Integration Officer	Ongoing	Ongoing

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 and monitored through the Planned Care Group
2	Theatre dashboard in place and monitored through the Planned Care Group
3	Patient Services Hub BI reporting suite in place covering all elective performance and reported and monitored through the Planned Care Group
4	DM01 diagnostic tools in place and reported and monitored through the Planned Care Group
5	Delivery of RTT and cancer performance and improvements reviewed through the Care Group PRMs
6	Reporting on RTT and cancer performance through the IPR with oversight by the Finance & Performance Committee and escalation to the Group Board, as required
7	Improved performance: sustained backlog reduction
8	Internal audit review of RTT pathways within ULTH during 2025 / 26 provided 'reasonable assurance)

Gaps in Assurance	
1	None identified
2	None identified
3	Detailed capacity and demand reporting not yet in place
4	None identified
5	None identified
6	None identified
7	None identified
8	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
3	Capacity and demand reporting tools in development by BI team	Group Chief Operating Officer	Group Deputy Chief Operating Officer	31 December 2026	Underway

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high quality care in the right place
Strategic Objective:	1b (iii): Reduce waiting times for our patients **(Out of hospital)**
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 in all care settings

Current Risk Score & Movement since last review:

10 (Moderate)



Last Review Date:	October 2026
Lead Executive:	Group Chief Operating Officer / Group Chief Integration Officer
Committee Oversight:	Finance & Performance Committee
Risk Appetite:	Open / Cautious

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	5	2	10 (Moderate)	Amber
Target	Mar-27	5	1	5 (Low)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	High	High	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Teams and pathways in place
2	Community waiting list improvement plan in place
3	Daily discharge meetings in place with senior oversight and system escalation to partners on stranded / delayed patients
4	Strong partnership working to improve referral quality, reduce avoidable demand and enhance care across pathways
5	Winter Plan in place
6	Power BI and daily validation

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Capacity challenges linked to workforce availability continue to be a challenge predominantly cover across all sites overnight
2	Community paediatrics remains the biggest risk within the community waiting list improvement plan
3	Discharge to assess capacity continues to be a constraint linked to patients awaiting transfer of care, primarily to adult social care
4	None identified
5	Insufficient capacity in place to develop and deliver the winter plan
6	Alignment of systems is required 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	Workforce improvement plan in development to improve overnight resilience	Group Chief Integration Officer	Group Deputy Chief Integration Officer	30 September 2026	Plan previously finalised, agreed and in place. Recruitment remains underway with the advert closing 9th October. Full integration of existing urgent response teams is complete with the Hospital at Home model in ongoing development. Phase 1 commenced in October which has provided both the integration of service and broadened the skill mix through CEMS inclusion.
2	Deliver community paediatric recovery / improvement plan	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 March 2027	Ongoing with key milestones delivered including consultant engagement programme, strengthening of clinical governance arrangements and agreement reached on consultant led multi-disciplinary model to support sustainable service delivery. GIRFT initial visit complete and currently reviewing recommendations. Successful in securing GIRFT investment.
3	Discharge and flow transformation programme in place supported by Newtons	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 March 2027	Better Flow, Better Care Programme (BFBC) established and has moved from initial design and diagnostic activity into detailed design and testing, with September focused on three priority areas: ward processes, Transfer of Care Hub (TOCH) processes and intermediate care flow. These are supported by Group-wide work on system visibility, effective system management and culture and organisational development, with the longer-term ambition of supporting sustainable reductions in acute demand and capacity requirements alongside the transition towards integrated neighbourhood working. October Sprint underway to support rapid roll out of impactful initiatives ahead of winter
4	Capacity redesign building on the winter mitigation schemes to be scoped for full delivery across 26/27 including use of CAS as safety net to all patients discharged on a supported pathway	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 October 2026	The transformation of Intermediate care services including those funded via the BCF and delivered by the group are a key workstream within the Better Flow Better care programme. This will ensure that any improvement work as a result of early pilots will be rolled out quickly, supporting winter, Additionally, the Community Connector provision has been retained. D2A expansion recruitment ongoing.
5	Continue to focus on community data to ensure clarity of service delivery and meeting patient outcomes. Next step is sharing data from Optica (see below)	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 October 2026	Optica has been rolled out across the acute trust, and continues with transition to BAU within the digital team. Operational and digital staff met with FDP during September to agree next steps around roll out of OneOptica within community. Additionally, the BFBC programme has established a system management group that will use all available acute and community data to understand demand and capacity with full visibility

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Community performance metrics and dashboards in place. Strong and sustained improvement against the community performance metrics including community waiting list. UTC 4-hour emergency access standard (Type 3) exceeding national target of 95%. UCR 2-hour response exceeding target of 80%.
2	Flow and Transfer of Care Steering Group in place and performance data presented. The BFBC programme now incorporated into the existing programme providing more visibility
3	Strong oversight of community waiting list and waiting list improvement plan: Adult community services continue to maintain zero patients waiting over 52 weeks. Adult 18 week recovery remains ahead of plan
4	Community performance data scrutinised through Planned and Unplanned Care Group PRMS with monthly oversight by the Finance & Performance Committee and reporting / escalation to the Group Board through the IPR

Gaps in Assurance	
1	None identified
2	
3	None identified
4	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
2a	Roll out of Optica discharge tool and reporting to all community services	Group Chief Integration Officer	Group Deputy Chief Integration Officer	31 October 2026	Continued focus on improving utilisation across all areas with all system partners now using Optica to manage their transfer of care pathways. This is supported by the Better Flow Better Care TOC hub and ward process working groups.Flow Better Care TOC hub and ward process working groups. Transitioned Optica to BAU in September, and operational and digital teams considering next steps for roll out of OneOptica (community) which will not be within October. Due Date will need to be revised
2b	Committee dashboards to include key group flow metrics linked to days lost due to transfer of care delays across acute wards, community wards (pathway 2) and the group pathway 1 offer	Group Chief Integration Officer	Group Deputy Chief Integration Officer	30 June 2026	Complete for Integration Committee. Feedback received to include in other Committees where appropriate
2c	Work underway with regional/national colleagues to ensure reporting tool and live Optica whiteboard sitrep in place	Group Chief Integration Officer	Group Deputy Chief Integration Officer	30 June 2026	Underway – update required Newton support to develop the dashboard for use. The Optica dashboard had previously been developed but has been superseded. Recommend closure

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 1: Patients

Strategic Aim:	Patients: Better Care – Timely, affordable, high-quality care in the right place
Strategic Objective:	1c: Improve productivity and deliver financial sustainability
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not manage costs effectively, optimise productivity and deliver our efficiency / cost improvement programmes then we will not **return to financial balance** resulting in poor use of public funds, increased regulatory / system scrutiny and unsustainable services for patients

Current Risk Score & Movement since last review:

16 (High)



Last Review Date:	August 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	Aug-26	4	4	16 (Moderate)	Amber
Target	Mar-27	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	High	High	High					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Green	Green	Green	Green	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

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Finance team structure still being configured
2	Financial literacy of the organisation not fully developed
3	Efficiency plans not yet fully developed and maturity of schemes requires additional work
4	Activity delivery target missed in months 1, 2 & 3 (impacted by industrial action)
5	Deep dive undertaken on scheme maturity in line with agreed timeline. Delivery of workforce / headcount reduction, adherence to workforce controls (e.g. bank and agency spend) and activity levels are key risks
6	None identified
7	None identified
8	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Complete the work to configure the finance team	Group Chief Financial Officer	Director of Operational Finance	Ongoing	Ongoing
2	Budget holder training rolled and responsibilities articulated to all budget holders as budgets are signed off: refresh required to ensure consistency across the organisation (high risk areas being targeted first)	Group Chief Financial Officer	Director of Operational Finance	31 December 2026	Underway
3	Develop and explore additional schemes to close off efficiency gaps	Group Chief Financial Officer	Care Groups / Corporate Directorates	31 October 2026	Underway. 'Star Chamber' events scheduled for September 2026
4	PMO tracking process being developed to provide forward assurance on efficiency delivery and activity position	Group Chief Financial Officer	Director of Operational Performance	31 October 2026	Underway
5	Deliver the financial plan and maximise CIP opportunities with a focus on high-risk areas	Group Chief Financial Officer	Care Groups / Corporate Directorates	31 October 2026	Underway

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of finance and key risks by the Finance & Performance Committee and reporting sub-groups with escalation to the Group Board as required
2	Reporting on finance KPIs to the Finance & Performance Committee and Group Board through the Integrated Performance Report (IPR): the group is delivering its agreed efficiency programme
3	Oversight of efficiency target delivery through PTOF and PRMs
4	Oversight of delivery of activity targets through the Planned Care Board
5	Internal & external audit arrangements in place
6	External productivity indicators (national indicators) outline good improvements in ULTH and LCHS.

Gaps in Assurance	
1	None identified
2	None identified
3	CIP scheme maturity is not yet fully tested
4	Trajectory required to ensure efficiency target delivery for full year
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
3a	Star Chamber being held to test CIP scheme maturity supported by PMO	Group Chief Financial Officer	Director of Operational Finance	30 June 2026	Completed
3b	Deep dive to be undertaken into additional efficiency schemes to close emergent gap	Group Chief Financial Officer	Director of Operational Finance	31 July 2026	Underway
4	Trajectory to be agreed	Group Chief Finance Officer / Group Chief Operating Officer	Director of Operation Finance / Group Deputy Chief Operating Officer	TBC	TBC

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description
ULTH	5020	20	Reliance on agency / locum UEC medical staff

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 whilst addressing our requirements for sustainability and our Green agenda
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. 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:

16 (High)



Last Review Date:	October 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	Aug-26	4	4	16 (High)	Amber
Target	Mar-27	4	3	12 (Moderate)	Amber

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	High	High	High	High	High	High	High					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Estates & Facilities Management (EFM) leadership & professional structures in place (including Authorising Engineers (AEs), Authorised Persons (APs) and Competent Persons (CPs). The Group Chief Estates & Facilities Officer 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 and EFM Transformation & Improvement Plans in place
4	EFM policies, processes, work plans and risk assessments in place covering HTMs, Health & Safety legislation and other statutory requirements
5	Six-facet survey completed for ULTH in 2024: good level of understanding of the estate's statutory compliance and critical infrastructure risks with clear ELT, Finance & Performance Committee and Group Board 'line of sight'
6	Decisions on EFM investment from the group's capital allocation are risk-based and prioritised based on the results from the six-facet survey and affordability
7	Alternative sources of capital continue to be explored wherever possible
8	ULTH and LCHS Sustainability & Green Plans published
9	Space Management Utilisation / Request Process in place

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Lack of EFM capacity due to the inability to recruit & retain suitably qualified staff. There is a need to harmonise the Emergency Preparedness, Resilience & Response arrangements across the group
2	Identified gaps in asset register and PPM regime and performance oversight.
3	Estates Strategy out of date
4	Some EFM policies & procedures require development as group documents
5	Six-facet survey requires regular update as estates evolve
6	None identified
7	None identified
8	Green Plans approved by the board in September 2026 but not yet embedded across the group
9	Full plotting of current locations usage is required. There are gaps in staff knowledge of space, rulesets & behaviours and internal resource

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
1a.	Work is on-going to try and make group wide appointments. Ongoing improvement to support recruitment and retention in line with National Staff Survey feedback	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	31 March 2027	Underway
1b.	Harmonise the EPR arrangements from two legacy organisations into a single, compliant framework – aligning policies, governance, command structures and business continuity plans to meet NHSE EPRR Core Standards	Group Chief Estates & Facilities Officer	Group Head of Emergency Planning	31 March 2027	Plan in development Group lead for EPRR to be appointed
2	In response to the recommendations identified through the external audit, a comprehensive PPM and Asset Improvement Plan has been established. This includes defined workstreams and dedicated task groups focused on delivering targeted improvements and ensuring sustained compliance. External partner secured to support with this work	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	31 March 2027	Underway with revised deadline
3	Complete the work to develop the Estates Strategy as a group document	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	~~31 October 2026~~ **Revised due date 31 December 2026**	Estates Strategy in development and will be finalised once the new Group Clinical Strategy is finalised and approved. Strategy due for board approval in October 2026 - Final estates strategy circulated; due to go board on 3rd Nov for sign off
4	Complete the work to align the EFM policies & procedures across the group	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	31 March 2027	Ongoing
5	Continue to update the six-facet survey as the estate evolves	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	Ongoing	Ongoing
8	Continue to embed the Green Plans across the group	Group Chief Estates & Facilities Officer	Group Head of Sustainability & Net Zero	31 March 2027	Ongoing

9	Reporting, PRM updates, communications, full CAD drawings of all sites being uploaded, full utilisation survey now procured, resource plan being recruited to	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	~~30 September 2026~~ **Revised due date 31 December 2026**	Underway - Survey is complete and actions are being reviewed

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 and internal reporting to Finance & Performance Committee.
2	External / independent review processes in place including AE annual audits and quarterly reviews across all HTMs 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 with 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.
8	Community: AE audit programme for relevant HTMs for LCHS premises in place & progress reported via Estates & Facilities Upward Report
9	Sustainability report submitted to the Green Group for oversight and assurance. Upward reporting to the Integration Committee and Group Board
10	Oversight of the Green Plans by the Integration Committee with upward reporting to the Group Board
11	Oversight of space management utilisation through Space Management Group with upward reporting to the Integration Committee

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	None identified
4	Reliability of LCHS Estates Returns Information Collection (ERIC) data continues to be improved
5	Shortfalls in housekeeping staffing levels, due to difficulties in recruiting, have the potential to impact on PLACE scores. Inability to access wards & clinical areas to undertake repairs due to site pressures has potential to affect PLACE scores
6	Opportunities need to be identified to further improve the quality of upward reports and strengthen data from NHS Property Services for sites that they are responsible for
7	There are Identified gaps in asset register and PPM regime performance oversight
8	AE audits for Ventilation, Pressure and Confined Spaces still to be completed
9	Progress of sustainability (Green Plan) actions not embedded across the group
10	There is a need for continued oversight of the embedding of the Green Plans
11	There is a need for a digital system to accurately monitor and report on space utilisation in greater depth in order to strengthen oversight and assurance

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		**Executive Lead**	**Operational Lead**	**Due Date**	**Progress**
1	Implement a Document Management Control Process in order to establish a clear process, standardisation and responsibilities for document lifecycle management and on-going practices	Group Chief Estates & Facilities Officer	Chief Estates & Facilities Officers	~~31 August 206~~ **Revised due**	Underway with revised timescale– This action is being progressed through PPM Recovery Board o support a consistent, group-wide approach to document

				date 31 January 2026	management and governance.
2	Undertake a full AE audit for all LCHS properties with a regular annual programme of audits and quarterly reviews to be put in place thereafter	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	31 March 2027	Ongoing
6	Continue dialogue and partnership working with NHS Property Services to improve upward reporting & escalation	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	Ongoing	Ongoing
7	Ensure that oversight of asset register and PPM regime performance is addressed as part of the PPM and Asset Improvement Plan	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	31 March 2027	Ongoing
8	Complete the outstanding AE audits	Group Chief Estates & Facilities Officers	Group Deputy Chief Estates & Facilities Officers	31 December 2026	Underway
9	Continue to embed sustainability (Green Plan) actions across the group	Group Chief Estates & Facilities Officer	Group Head of Sustainability & Net Zero	Ongoing	Ongoing
10	Review Sustainability sub-group (Green Group) terms of reference & effectiveness	Group Chief Estates & Facilities Officer	Group Head of Sustainability & Net Zero	31 August 2026	Complete – This is complete and a paper went to FPC recommending a way forward to retain the Green Group
11	Procure digital system to accurately monitor and report on space utilization	Group Chief Estates & Facilities Officer	Group Deputy Chief Estates & Facilities Officers	31 March 2027	Underway

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**

Strategic Aim 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, underpinned by a positive and inclusive culture
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **foster a positive and inclusive culture that supports high-quality training, development and education**, our people will be unable to fulfil their potential or support the delivery of new models of care, leading to reduced quality, increased risk of avoidable harm, inefficiency and challenges in attracting and retaining staff.

Current Risk Score & Movement since last review:

Low (6)



Last Review Date:	October 2026
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	3	3	Low (6)	Green
Target	Mar-27	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Green



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Low	Low	Low	Low					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Green	Green	Green	Green					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Education and Talent Team working with Care Groups to on focused areas where compliance is <90%. ESR Hierarchy reviews planned twice per year to support accurate reporting and management of non-compliance
2	Further opportunities being developed for improving productivity and integration through a 'grow our own' approach and optimization of all education funding, including maximization of apprenticeship levy
3	Education Oversight Group in place, which monitors, escalates and reports on use of different funding streams and mandatory training compliance (including that of new starters)
4	Processes in place for holding Care Groups/Corporate Directorates to account for the delivery of people KPIs and improvements to support ownership at local level and develop a culture of continuous improvement
5	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
6	Deep dives including role specific training where compliance levels are insufficient
7	Development of training and education to support staff transitioning through left-shift change

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	Awareness of wider group training needs analysis process, in particular for non-registered staff
3	None identified
4	None identified
5	Await NHS England guidance in relation to Lead Employer model expansion
6	Divisional/Clinical Care Group Leadership Teams awareness of uptake and compliance rates of role specific training
7	Development of training in line with future activity not yet determined

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, 6	Education and Talent team sharing information with the Care Group Leadership teams and following up to offer support in order to increase compliance. Processes in place to improve statutory and mandatory training compliance support and reporting arrangements, including enhanced access to compliance data, targeted communications and leadership support arrangements. Support sessions happening across range of sites and virtually to assist both staff and leaders with improved compliance.	Group Chief People Officer	Associate Director of Education and Talent	30 June 2026	Completed
1, 6	Strategic Business Partners working with Care Group Leadership Teams to ensure appropriate support in place for all People metrics.	Group Chief People Officer	Associate Director of HR	30 September 2026	Completed
2	Develop a process to centrally record training needs for non-registered staff (*ready for next year's appraisal/TNA cycle).*	Group Chief People Officer	Associate Director of Education & Talent	31 March 2027	Ongoing
2	Promote the education and training offers available to ensure leaders and staff aware how to access these. The new 'one stop shop' Education and Training sharepoint pages were launched in May, with support webinars also being held. The sharepoint site is regularly reviewed and updated.	Group Chief People Officer	Associate Director of Education & Talent	30 June 2026	Completed
5	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
7	Future roles to be understood in order to define required education and training for staff.	Group Chief People Officer	Associate Director of Workforce / Associate Director of Education and Talent	31 March 2027	Ongoing

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 Performance Report. Mandatory training compliance continues to improve
3	Reporting on medical and non-medical education and medical revalidation to the People Committee
4	Reporting on safer staffing (including training and knowledge gaps) to the People Committee
5	Monthly PRM meetings take place which review KPIs against targets, and this is reported at overall Trust level at People Committee within the scorecard. Active engagement with Care Groups throughout both the annual planning process, Plan for Every Post meetings and Workforce Strategy Group continue monthly
6	National and regional benchmarking data considered through the People Committee and reporting sub-groups
7	Reporting against Resident Doctor 10 Point Plan reported to People Committee

Gaps in Assurance	
	None identified
2	None identified
3	None identified
4	None identified
5	None identified
6	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
7	None identified

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
6	Further enhancing all sub-groups to incorporate benchmarking (using as a minimum Model Hospital data) as regular agenda items in 2026/27. Discussions have taken place at each sub-group to identify what benchmarking information is available and would be relevant. Work is underway to obtain this and will then be incorporated into future agendas.	Group Chief People Officer	Group Deputy Director of People	30 July 2026	Completed

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description
ULTH	5450	20	Risk of Gastro service not being viable due to current fragility of Consultant workforce

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: Create a culture that empowers our people to deliver change through continuous improvement and innovation
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **foster a strong, inclusive and enabling culture that empowers our people to continuously improve and innovate**, they will feel unable to perform their roles effectively and take ownership of change. This will limit our ability to deliver the required transformation in the quality, efficiency and effectiveness of our services, resulting in a disengaged and disenfranchised workforce, poorer clinical outcomes and diminished patient experience.

Current Risk Score & Movement since last review:

Moderate (9)



Last Review Date:	October 2026
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	3	3	Moderate (9)	Amber
Target	Mar-27	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	All education, learning and development programmes and KPIs in place
2	LCHG Way including engagement 'Tube Map' – 'Better Together' Programme
3	Improved job planning compliance rate to 95% with supporting evidence in place, and a move towards a prospective cycle
4	Improved vacancy control 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. This will become transparent through upward reports and cross referrals into integration committee as appropriate
7	Workforce Planning and CIP Delivery
8	New leadership programme to foster culture of improvement and innovation
9	Work Well Plan in place

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Confirmation required that all education, learning and development programmes in place across the Group
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	Confirmation of CIP delivery against workforce plan
8	Ability to measure impact the leadership programme is having on the culture
9	

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 Oversight Group to be provided with assurance that all education, learning and development programmes are in place, including medical and nursing.	Group Chief People Officer	Associate Director of Education and Talent	31 August 2026	Completed
2	Staff awareness at all levels of group strategy, values, behaviours and approach (LCHG Way) to innovation and continuous improvement remains ongoing and will form part of a rolling programme of regular communications and engagement in 2026 / 27. This has been embedded into the Quality Fundamentals Rounds and will continue to evolve. Including through GLT Tours and alignment with the Work Well Plan activities.	Group Chief People Officer	Deputy Director of People/Associate Director of Culture	31 March 2027	Ongoing
4, 7	Seals of approval process to be established with revision of VCP process. Care Groups having robust mechanism and control on decision made in line with plan for every post and delivery of CIP, supported by the implementation of seals of approval for vacancies. This is complete. The new process was implemented on 01 June 2026 with FAQ's and Lunch & Learning sessions and was received positively, with ongoing reviews planned in year to maintain assurance against workforce plan.	Group Chief People Officer	Associate Director of HR / Associate Director of Workforce	30 June 2026	Complete
8	Develop and monitor specific NSS/NQPS questions to assess impact (ie relating to staff ability to make improvements happen in their area of work, make suggestions etc)	Group Chief People Officer	Associate Director of Culture & Wellbeing	31 March 2027	Ongoing

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Upward Reporting: Pulse Survey and NHS Staff Survey results are reported to the Executive and Group Leadership Team, People Committee and Group Board and culture action plans are monitored through GLT, PRMs and Culture and Leadership and upwardly report to the People Committee with escalation to the Group Board as required.
2	
3	Oversight of the people agenda and key risks by the People Committee and reporting sub-groups with escalation to the group board as required. Reporting on people KPIs to the People Committee and Group Board through the Performance Report
4	
5	Oversight of research & innovation has transferred to the Integration Committee

Gaps in Assurance	
1	None identified
2	
3	None identified
4	
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	None identified				

Related risks on Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description
ULTH	5093	20	Procurement service staffing levels (Pharmacy)
ULTH	4844	20	Staffing levels requiring an increase in Pharmacy to provide 7 day dispensing service
ULTH	5761	20	Risk to IBD 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:	October 2026
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Open

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	3	3	Moderate (9)	Amber
Target	Mar-27	3	2	Low (6)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	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 with underpinning behavioral framework in place – 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 care group and directorate culture 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
9	Work Well Plan
10	Well Led Review and Single Organisation action plan

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Staff awareness at all levels of group strategy, values and behavioral framework
2	The review of HR policies and T&Cs will take time to complete due to required engagement with all stakeholders
3	None identified
4	Delivery of pulse surveys and NHS staff survey culture action plans at operational level needs to be incorporated into the PRM process
5	None identified
6	None identified
7	None identified
8	None identified
9	
10	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Staff awareness at all levels of group strategy, values, behaviours and approach (LCHG Way) remains ongoing and will form part of a rolling programme of regular communications and engagement in 2026 / 27. This has been embedded into the Quality Fundamentals Rounds and will continue to evolve. Including through GLT Tours and Work Well Plan activities	Group Chief People Officer	Deputy Director of People/Associate Director of Culture	31 March 2027	Ongoing
2	LCHG Policy Group continues to work collaboratively to review policies at pace. 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 December 2026	Underway – on track
4	OD Team are working together with the Workforce Intelligence team to include scores and cultural action plans in PRMS. A process is now in place for these plans and updates to be included in each area's PRM.	Group Chief People Officer	Associate Director of Culture	30 June 2026	Completed
9	Work Well Plan to be communicated to staff for awareness and progress updates to be reported through Workforce Strategy Group. Name changed to Work Well Plan and this has been approved at board and launched across Group. Plans are being actively delivered with a Work Well campaign calendar developed for roll out to organisation with effect from quarter 3.	Group Chief People Officer	Deputy Directors of People	31 March 2027	Ongoing

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 EDI and Culture and Leadership Groups with upward reporting to the People Committee and escalation to the Group Board as required
4	Pulse Survey and NHS Staff Survey results are reported to the Executive and Group Leadership Team, People Committee and Group Board. Care group and directorate culture action plans are monitored through PRMs with the organisatoinal culture action plan reported through Culture and Leadership Group with upward reporting to People Committee and escalation to the Group Board as required.
5	People KPIs / metrics are reported through the Performance Report 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 EDI Group and upwardly to the People Committee
9	Staff well-being offer is monitored through discussion with staff side and through the Culture and Leadership Group, Work Well Plan reporting and upwardly to the People Committee
10	Internal audit review of the people agenda provides independent assurance and / or escalation of risks.

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	None identified
3	None identified
4	Monitoring of culture action plan progress is not fully embedded within PRMs
5	None identified
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, 6, 7	Develop a People Heat map covering all data sources to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership Group Workforce Strategy Group on a monthly basis with onward upward reporting to People Committee. Plan to have a heatmap which incorporates quality, culture and people metrics to support triangulation of multiple data sources and lenses. Completion date refreshed to November 2026 in view of this.	Group Chief People Officer	Deputy Director of People	~~30 September 2026~~	Ongoing **Revised due date 30 November 2026**
4	OD Team are working together with the Workforce Intelligence team to include scores and cultural action plans in PRMs. .A process is now in place for these plans and updates to be included in each area's PRM.	Group Chief People Officer	Associate Director of Culture	30 June 2026	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 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:	October 2026
Lead Executive:	Group Chief People Officer
Committee Oversight:	People Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	3	2	Low (6)	Green
Target	Mar-27	3	1	Very Low (3)	Green

Assurance Rating & Movement since last review:

Green



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Low	Low	Low	Low	Low	Low	Low					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Green	Green	Green	Green	Green					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Reward and Recognition Policy
2	Reward and Recognition Lead to support ongoing work streams from 'People Promise' themes and LCHG Work Well Plan
3	ELT visibility and recognition of staff and teams through established communication and engagement channels e.g. GLT Tours and long service awards
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
6	Values in action certificates
7	Achievement of regional and national recognition awards

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	None identified
2	None identified
3	None identified
4	Leaders utilising informal feedback across the year to support annual staff award nominations
5	None identified
6	None identified
7	Support and awareness to enable applications/nominations to be submitted for awards

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
4, 7	Culture and Communications teams to provide support and guidance to those completing applications/nominations	Group Chief People Officer	Associate Director of Culture / Deputy Director of Communications	30 September 2026	Completed
7	Culture and Communications teams to work together to identify potential application/nomination opportunities for LCHG / individual organisations	Group Chief People Officer	Associate Director of Culture / Deputy Director of Communications	31 March 2027	Underway

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) and summary of recognition activity, reporting to Culture and Leadership Group
2	Pulse Survey and NHS Staff Survey results are reported to the Executive and Group Leadership Team, People Committee and Group Board. Care group and directorate culture action plans are monitored through PRMs with the organisatoinal culture action plan reported through Culture and Leadership Group with upward reporting to People Committee and escalation to the Group Board as required
3	Pastoral care award received for recruitment and on-boarding of international nurses
4	Internal audit of people agenda provides independent assurance
5	Staff Stories received by People Committee

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 culture action plan progress is not fully embedded within PRMs
3	None identified
4	None identified in respect of reward and recognition
5	No standardised agenda item for reporting groups of the Committee to support identification of staff stories

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 People Heat map covering all data sources to enable triangulation and highlighting of cultural trends and issues with reporting into the Culture and Leadership Group / Workforce Strategy Group on a monthly basis with onward upward reporting to People Committee. Plan to have a heatmap which incorporates quality, culture and people metrics to support triangulation of multiple data sources and lenses. Completion date refreshed to November 2026 in view of this.	Group Chief People Officer	Deputy Director of People	~~30 September 2026~~	Underway **Revised due date 30 November 2026**
2	OD Team are working together with the Workforce Intelligence team to include scores and cultural action plans in PRMs. A process is now in place for these plans and updates to be included in each area's PRM.	Group Chief People Officer	Associate Director of Culture	30 June 2026	Completed
5	Standardise formal agenda item across all reporting groups of the Committee to support identification of staff stories. Staff stories included as a standard agenda item within Culture & Leadership Group and Education Oversight Group. It will be added to Equality, Diversity and Inclusion Group and Workforce Strategy Group from the September agenda onwards.	Group Chief People Officer	Deputy Directors of People	30 June 2026	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:	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:

6 (Low)



Last Review Date:	October 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	Aug-26	3	2	6 (Low)	Green
Target	Mar-27	3	1	3 (Very Low)	Green

Assurance Rating & Movement since last review:

Green



Risk Score	**Apr-26**	**May-26**	**June-26**	**Jul-26**	**Aug-26**	**Sept-26**	**Oct-26**	**Nov-26**	**Dec-26**	**Jan-27**	**Feb-27**	**Mar-27**
	Low	Low	Low	Low	Low	Low	Low					

Assurance Rating	**Apr-26**	**May-26**	**June-26**	**Jul-26**	**Aug-26**	**Sept-26**	**Oct-26**	**Nov-26**	**Dec-26**	**Jan-27**	**Feb-27**	**Mar-27**
	Green	Green	Green	Green	Green	Green	Green					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Left Shift transformation programme agreed focussed on key specialties and being managed through the Alliance Care Group
2	Blueprint agreed to move specialties between Care Groups (e.g. from Medicine to Alliance)
3	Robust CIP and transformation delivery programme in place monitored through the Productivity, Improvement and Transformation Forum (PITOF)
4	Neighbourhood Health Readiness Programme in place and managed through the Alliance Steering Group
5	Partnership Plan in place to support transformation. Effective partnership working and reporting in place
6	Neighbourhood Board established to oversee, support collaboration and delivery alignment, which includes external partners and will support delivery of the Left Shift programme and Strategic Neighbourhood Health and Care Plan linked to the national Neighbourhood Framework
7	A Health Inequalities Working Group has been established to support improvement, guided by the Health Inequalities Maturity Matrix
8	Developing estates strategy for rationalisation and business cases for maternity and theatres

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Cultural mindset and staff engagement are not yet consistently embedded or fully cascaded across all levels of the organisation
2	There is a need for escalation for pace and resolving issues with internal department transfers
3	There is a need to consistently evidence impact of transformation on length of stay, unnecessary attendances and admissions
4	
5	None identified
6	None identified
7	Process of embedding HI as BAU within the Care Groups is still underway
8	Group Estates Strategy not yet finalized

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	Specialty workshops, comms and engagement plan, workforce readiness programme being delivered to support delivery of Left Shift	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Deputy Chief Integration Officer	31 August 2026	Completed & Ongoing
3.	Establish and embed a consistent outcomes and reporting framework that tracks and evidences the impact of transformation on length of stay, avoidable attendances and admissions, with clear ownership, baseline measures and regular Board-level reporting.	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	30 September 2026	In development
4.	Strategic delivery partner to support implementation of the Newton diagnostic recommendations is currently being procured.	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign	30 June 2026	Completed – delivery partner in place
7.	Health Inequalities plans for Care groups have been developed and are being finalised as part of their 26/27 operational plans.	Group Chief Integration Officer	Deputy Director of Strategic Partnership	30 June 2026	Completed
8.	Work with Archus as the external delivery partner to agree the LCHG Estates Strategy which will be informed by the Clinical Services Strategy and support delivery of Left Shift and Neighbourhood Health.	Group Chief Integration Officer	Group Deputy Chief Estates & Facilities Officers	31 October 2026	Underway

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of Left Shift transformation work streams by Alliance Steering Group, PITOF Integration Committee with escalation to the Group Board as required
2	PITOF upward reports to the Integration Committee include reporting on delivery of key KPIs and milestones. 2026/27 PITOF programme approved by SROs and added to Monday.com to supporting reporting processes
3	IPR to support demonstration of a positive shift in key metrics such as improved LOS, improved staff and patient satisfaction, improved access to services

Gaps in Assurance	
1	Consistent representation at Alliance Steering Group and ownership of the transformation by key operation and corporate leads. Consistent communication and engagement with Left Shift specialties to have a collective view on transformation programme.
2	None identified
3	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 of ASG work programme, membership and TOR as an opportunity to refocus ownership and attendance	Group Chief Integration Officer	Group Director Strategy, Improvement and Redesign / Group Deputy Chief Integration Officer	31 August 2026	Completed

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:

6 (Low)

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Last Review Date:	October 2026
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	3	2	6 (Low)	Green
Target	Mar-27	3	2	6 (Low)	Green

Assurance Rating & Movement since last review:

Green

⇔

Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Low	Low	Low	Low	Low	Low	Low					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Green	Green	Green	Green	Green	Green	Green					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Health Inequalities embedded as a key organisation / system priority within the Group Strategy and operational and financial plans
2	Population health is embedded in the Transformation & Improvement Programme
3	Mandatory Health Equality Assessment Tool (HEAT) in place and utilised for all transformation projects and business cases
4	Health Inequalities and Personalisation Working Group in place to oversee delivery of the Population Health Management Plan
5	There is 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	Health inequalities and personalisation actions have been agreed and are embedded in Care Group operational plans

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	There is limited focus on prevention / health inequalities in the system strategy & a lack of investment in prevention which may be further impacted with ICB changes
2	There is a need for evidence of implementing population health management in discussions/decisions/ improvement
3	There is a gap in resource to manage HEAT in the medium – longer term term
4	There is a need to agree the longer term approach to overseeing health inequalities and personalisation and to agree an LCHG Co-production Strategy
5	Work is needed to embed the consistent use of data in planning. ICB changes may pose a risk to sustainability of the linked data set: the population health database for Lincolnshire (Optima) is used to track health inequality metrics. The ICB are looking to develop an in-house version
6	The is currently a lack of Care Group capacity to engage, embed knowledge and to ensure delivery. There is also a need to provide evidence of impact

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	Develop an approach to prevention through the Lincolnshire Neighbourhood Health and Care Board within the resilient communities tier in the operating model	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 August 2026	Completed
3	Monitor completion of HEAT as part of transformation projects and business cases, and explore long term options or any additional resources needed to ensure we meet our statutory requirements on health inequalities	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 December 2026	In progress
4	Develop LCHG Co-production strategy to support the embedding of Personalisation within LCHG	Group Chief Nurse	Group Head of Patient experience and Volunteer Services	31 December 2026	In progress
5	Embed HI in the continuous planning approach	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 August 2026	Completed
6	Provide proactive support to care groups once operational plans confirmed on health inequality and personalization metrics	Group Chief Integration Officer	Group Director of Strategy, Improvement and redesign	30 September 2026	Complete

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight of delivery of the Health Inequalities and Personalisation Action Plan through the Health Inequalities and Personalisation Working Group and Integration Committee with escalation to the Group Board as required
2	Tackling health inequalities is a key area of focus within the board development programme
3	Neighbourhood Health and Care Board in place with oversight of the resilient communities element of the Neighbourhood Operating Model
4	TIAA health inequalities audit results demonstrates 'reasonable assurance'
5	Delivery of Care group level health inequalities and personalization plans are monitored through PRMs

Gaps in Assurance	
1	None identified
2	None identified
3	There is a lack of clarity in the role of health providers in the resilient communities part of the Neighbourhood Operating Model e.g. stakeholder vs lead
4	None identified
5	Monitoring through PRMS needs to be strengthened now that plans have been agreed

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	Confirm plan for resilient communities via the Neighbourhood Health and Care Board and role of LCHG to support delivery	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 August 2026	Completed – Neighbourhood Governance signed off with LCC leading resilient communities and Health Places Programme

2	Establish robust and routine monitoring through PRMs supported by Strategic Business Partners	Group Chief Integration Officer	Group Director of Strategy, Improvement and redesign	30 September 2026	In progress - established in surgery and FH, work ongoing in other care groups and will be supported by new SBP's

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 (i): Enhance our digital capability through innovation delivering the 10-year health plan
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enhance our digital, Innovation** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale

Current Risk Score & Movement since last review:

12 (Moderate)



Last Review Date:	October 2026
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	4	3	12 (Moderate)	Amber
Target	Mar-27	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	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	Optimisation of LCHG Digital Service for LCHS, Lincs ICB corporate and GPIT along with Transition of LPFT Digital Service to LCHG to enable and integrated digital approach
4	Disaster Recovery Plans in place. Cyber security & malware processes in place and tested, with 26/27 audit regime agreed.
5	Digital Oversight Group in place to driver delivery of digital agenda – with Digital Approvals Board reviewing and assessing all digital demands to ensure strategic alignment and priority.
6	Digital Business Partnering team established to support improved engagement and enabling 'digital as a partner' approach to be embedded.

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 – high touch EPR support to be provided
2	Insufficient capital / revenue to replace ageing technology – working with Finance teams to support multi year planning
3	Alignment and change to operating model of LCHG Digital services to scale to the combined requirement, including transition.
4	Effectiveness of operational business continuity plans
5	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Commencement of the AVT (Ambient Voice Technology) rollout in clinical early adopter areas	Group Chief Integration Officer	Group Director of Digital Services	Ongoing	Phase 1 commenced, business case to CRIG 29/10. AccuRX live in CAS and Community Peads. ENT, T&O and Cardiology to go live shortly (mid to late October)
2	Rollout of AI (Co-pilot) across organisation	Group Chief Integration Officer	Group Director of Digital Services	Ongoing	Licenses available and being deployed. Rollout now underway
3	Design the community wide Patient Engagement Portal (PEP), including integration into NerveCentre, SystmOne and NHS App	Group Chief Integration Officer	Group Director of Digital Services	TBC	Scoping work commenced with PWC
4	Improve digital literacy / capability / skills of workforce to use AVT, AI, etc.	Group Chief Integration Officer	Group Director of Digital Services	Ongoing	Tech Bars now open. Digital Download sessions establish. Training and user guides being developed
5	Establish Deputy Director of Innovation role	Group Chief Integration Officer	Group Director of Digital Services	Ongoing	Innovations matrix group established. Forms part of Digital structure review
6	Stabilise and optimise the Digital Service post move to LCHG from AGEM and transition LPFT digital services to LCHG	Group Chief Integration Officer	Group Director of Digital Services	Ongoing	Digital fit for the future review underway, future operating model being developed.

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 moved from AGEM to LCHG
5	Output of exercise upwardly reported and actions owned and forms part of regular EPG reporting.

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	Due Date	Progress

			Lead		
4	ULHG Technical Digital Service Assurance reporting to optimisation of LCHG services from AGEM as 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	Ongoing	Ongoing

Related risks on Risk Register – ULTH			
Trust	**Datix ID**	**Score**	**Summary Risk Description**
ULTH	5812	20	Board Assurance Framework overarching cyber risk

Related risks on Risk Register – LCHS			
Trust	**Datix ID**	**Score**	**Summary Risk description**
LCHS	5812	20	Board Assurance Framework overarching cyber risk

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3c (ii): Enhance our digital capability through delivery of our EPR in 26/27/28
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enhance our digital care models through EPR** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale

Current Risk Score & Movement since last review:

12 (Moderate)

⇔

Last Review Date:	October 2026
Lead Executive:	Group Chief Integration Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	4	3	12 (Moderate)	Amber
Target	Mar-27	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	EPR and EDMS programmes under way, both strategic enablers, EPR tranche 1 go-live Oct 26
2	Digital Strategy for the group developed with a focus on digital transformation, integration & new ways of working
3	Digital systems across the group mapped and plan developed to align. 'Enabling Technology Programme in place to deliver improved technical infrastructure
4	Programme of work in place to deliver standard/secure infrastructure across community sites, delivering the same standard as on Acute sites
4	Digital Oversight Group in place to driver delivery of digital agenda, with Technical Design Authority supporting alignment of digital standards across Group.

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Capacity within the digital team to deliver the digital transformation – new prioritization approach introduced to ensure digital demands capture and assessed.
2	There is a need to enhance digital capability & skills through training
3	Insufficient capital / revenue to replace ageing technology – working with Finance teams to support multi year planning
4	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	NerveCentre: 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	Ongoing	Complete While programme resourcing continued to be a focus this is now stable and forms part of BAU programme leadership.
1	NerveCentre: 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	Complete All key/senior roles now filled for implementation Stage and review/recruitment of roles forms part of BAU programme leadership and is stable.
3	SystmOne: delay to EPS/EPMA due to NHSBSA pharmacy coding but on plan for completion now - which will complete the EPR implementation.	Group Chief Integration Officer	Group Director of Digital Services	31 May 2026	This is technically ready and we are waiting on the pharmacy team to sign off on their processes and provide a go-live date

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 – 2026 version in progress
3	EPR Updates to IC

Gaps in Assurance	
1	None identified
2	None identified
3	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					
2					
3					

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 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3c (iii) Enhance our research and innovation capability linked to our population health needs
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not **enhance our research and innovation capability** then we will be unable to effectively transform key clinical pathways and support staff to work more flexibly and efficiently resulting in poorer clinical outcomes, poor patient experience and reduced staff satisfaction and morale

Current Risk Score & Movement since last review:

12 (Moderate)

⇔

Last Review Date:	October 2026
Lead Executive:	Group Chief Medical Officer
Committee Oversight:	Integration Committee
Risk Appetite:	Hungry

Risk Score		Severity	Likelihood	Overall Risk Score	Assurance Rating
Current	Aug-26	4	3	12 (Moderate)	Amber
Target	Mar-27	4	2	8 (Moderate)	Green

Assurance Rating & Movement since last review:

Amber

⇔

Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Amber	Amber	Amber	Amber	Amber	Amber	Amber					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Key group focus on research and innovation including Artificial Intelligence (AI)
2	The group has initiated planning and engagement activities to support a future application for membership of the University Hospital Association
3	There is monthly oversight of 150 day performance via the Research & Development Operations Group
4	Active dataset validation underway to correct the group's reported position
5	Targeted communications & engagement plan in place for PIs and to support departments (60 day set up, 30 day first patient)
6	Lessons learned processes classify internal/group/external delays for each breach
7	Standing RIGG agenda item for 150 day performance

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	LCHG Research & Innovation Strategy to be re-visited following initiation of a programme of work to support a future application for membership of the University Hospital Association
2	Gap analysis required
3	Limited capacity across Research Support Office, Research Delivery and Clinical Trials Pharmacy delaying activation and compliance
4	Inconsistent PI protected time and variable responsiveness in support services (Radiology, Medical Physics, Estates, Digital)
5	National data quality and local validation issues limiting reliable monitoring.
6	None identified
7	None identified

Actions being taken to address gaps in controls *(What are we going to do, by when, to further manage and mitigate the risk?)*		Executive Lead	Operational Lead	Due Date	Progress
1	LCHG Research & Innovation draft Strategy being re-visited in line with the shifting ambition to apply for University Hospital Association membership	Group Chief Medical Officer	Head of Research & Innovation	30 September 2026	Underway
2	Gap analysis in respect of the above application to be completed and resource required to be identified and report to be submitted to the Integration Committee	Group Chief Medical Officer	Head of Research & Innovation	30 December 2026	Underway
3	A capacity recovery plan for the Research Support Office, Research Delivery and Clinical Trials Pharmacy has been developed, aiming to reduce the backlog and ensure compliance. The plan is due to be submitted to ULTH CRIG and Charities Committee.	Group Chief Medical Officer	Head of Research and Innovation	30 October 2026	Constraints identified, options scoped, business case in development
4a	Implement communications & engagement plan for all PIs and support services	Group Chief Medical Officer	Head of Research and Innovation	31 May 2026	Completed
4b	Map recurrent internal delays (capacity, contracts, pharmacy) and escalate systemic issues to Integration Committee (quarterly)	Group Chief Medical Officer	Head of Research and Innovation	Quarterly Ongoing	Lessons learned process established
5	Complete validation of national 150 day dataset to enable accurate internal performance reporting and trend analysis	Group Chief Medical Officer	Head of Research and Innovation	30 April 2026	Completed – data validation process established

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Monthly R&D Operations Group review of studies withing the 150 day window
2	Upward reporting to Integration committee once dataset validation completes

Gaps in Assurance	
1	No validated, routine reporting yet available to provide full Board assurance on 150 day compliance
2	Limited assurance that supporting services have capacity/prioritization aligned to research timelines

Actions being taken to address gaps in assurances *(What are we going to do, by when, to ensure the required assurances are in place?)*		Executive Lead	Operational Lead	Due Date	Progress
1	Integrate 150-day performance into existing corporate oversight cycles (RIGG, Integration Committee) to provide multi line assurance once validated data is available.	Group Chief Integration Officer	Head of Research & Innovation	May 2026	Completed – 150 day metric already a standing item at RIGG; upward reporting planned post validation.
2	Develop cross service assurance framework to evidence Radiology, Pharmacy, Medical Physics, Estates and Digital readiness for 150 day set up timelines.	Group Chief Integration Officer	Relevant Service Leads / Group Director of Digital Services	30 June 2026	Completed – Dependencies mapped through lessons learned work; assurance framework in planning.

Related risks On Risk Register – ULTH			
Trust	Datix ID	Score	Summary Risk Description

Related risks on Risk Register – LCHS			
Trust	Datix ID	Score	Summary Risk description

Strategic Aim 3: Population

Strategic Aim:	Population: Better Health – Improve population health
Strategic Objective:	3d: Delivery of a better health and care model for our neighbourhoods through partnership working with other organisations and our communities
Strategic Risk: (How we may be prevented from meeting objective and what is the potential impact)	If we do not listen to the needs and wants for our communities and deliver an aligned approach in collaboration with our partners, we will continue to duplicate care and deliver inefficient outcomes

Current Risk Score & Movement since last review:

6 (Low)



Last Review Date:	October 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	Aug-26	3	2	6 (Low)	Green
Target	Mar-27	3	2	6 (Low)	Green

Assurance Rating & Movement since last review:

Green



Risk Score	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Low	Low	Low	Low	Low	Low	Low					

Assurance Rating	Apr-26	May-26	June-26	Jul-26	Aug-26	Sept-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	Green	Green	Green	Green	Green	Green	Green					

Identified Controls *(What are we already doing to manage the risk?)*	
1	Partnership & Engagement Strategy in place. There is strengthened integrated working with Primary Care/GPs/PCNAs
2	Neighbourhood Health & Care Board in place
3	Personalisation and community engagement framework in place, supported by co-production principles, to ensure that service users, carers, and local communities are actively involved in the design, delivery, and evaluation of services
4	INT blueprint including Integrated staffing model , leadership and governance, pathways and cohorts etc
5	Insights performance dashboard in place aligned to the five national goals and local metrics which is reviewed through the Neighbourhood Health & Care Board
6	There are plans for co-design of neighbourhood health priorities with local communities

Gaps in Controls *(What are the gaps in control that are required to manage the risk)*	
1	Neighborhood Health and Care Plan not yet agreed
2	There is inconsistent or insufficient receipt of updates from key partner groups, including the Health and Wellbeing Board, Mental Health Alliance, LDN Alliance, and ICB cluster boards, resulting in limited visibility of cross-system developments, priorities, and decision-making
3	There is a lack of consistent, structured approach to involving service users, carers, and communities in service design and delivery. This limits opportunities for co-production, reduces the effectiveness of engagement activities, and weakens the ability to address health inequalities and respond to local need.
4	Definition of INT geography still to be agreed
5	Local metrics to be developed (national guidance indicates this is to be led by the ICB)
6	Co-production framework still to be determined

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	Neighbourhood Health and Care Plan to be agreed – this will be led by the new Lincolnshire Health and Wellbeing Place Partnership	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	~~31 July 2026~~ **Revised due date 31 Dec 2026**	Plan developed but not yet agreed
2	Map established governance processes, with named representatives attending key partner forums and sharing updates through regular reporting, briefings, and escalation routes to improve visibility of cross-system developments and decision-making.	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 July 2026	Completed & Ongoing as part of Partnership & Engagement Strategy
3	Work collectively with partners to develop our personalisation framework	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	30 November 2026	In development – Personalisation and co-production lead has joined the Neighbourhood Health and Care Board along with the SRO
4	Develop a full INT blueprint as part of the Neighbourhood Health and Care Plan to deliver the national Neighbourhood Framework (end of Q1). LCHG will implement this once approved – this will be led by the new Lincolnshire Heath and Wellbeing Place Partnership	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	~~30 June 2026~~ **Revised due date 31 Dec 2026**	Ongoing
5	Embedding national metrics is part of the Neighbourhood Health and Care Plan to deliver the national Neighbourhood Framework (end of Q2). LCHG will use the dashboard to measure INT/NH outputs/outcomes once developed.	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 December 2026	Underway

Sources of Assurance (1st, 2nd and 3rd Line) (How we know the controls are working effectively)	
1	Oversight through the Alliance Steering Group and Integration Committee
2	Group CIO is chair of the Neighbourhood Health and Care Board

Gaps in Assurance	
1	ASG work programme currently under review to clarify operational or transformational reporting routes aligned to the 2026/7 work programme.
2	Programme management resource to support delivery of the Neighbourhood Health and Care Board action plan/work programme is to be 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	Revised work programme and TOR due at Alliance Steering Group in June 2026	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	30 June 2026	Completed
2	Programme resource to support delivery of the Neighbourhood Health and Care Board action plan and work programme being scoped	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 August 2026	To be discussed and agreed through the Neighbourhood Health & Care Board with a view to

					establishing a system PMO model
3	Finalise and stand up system PMO across health and care provider partners	Group Chief Integration Officer	Group Director of Strategy, Improvement and Redesign	31 October 2026	In progress

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 November 2026*
Agenda item number	*12.3*

Audit and Risk Committee Upward Report of the meeting held on 26 October 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 November 2026
Report from:	Audit and Risk Committee
Report from meeting held on:	26 October 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 26 October 2026 including assurances received and those matters which the committee wish to escalate to the Group Board.

2.0 Matters considered by the committee

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

a) External Audit Progress Report
b) Internal Audit Progress Report
c) Local Counter Fraud Progress Report
d) Internal Audit Progress Report
e) Compliance Report
f) Standing Orders and Standing Financial Instructions
g) Board Assurance Framework
h) Risk Report and External Risk Review
i) Policies and Procedures

The External Audit provider offered assurance to the Committee that planning for the 2026/27 year end review was going well. All relevant steps were in place and the required resource to complete the work had been allocated. There was no update in terms of the 2025/26 review and whether further instructions would be issued from the NAO. This was still awaited.

The Internal Audit provider offered their progress report, an update around audit recommendations and the Internal Audit Standards Essential Conditions document. The Committee received Internal Audit reports in respect of Duty of Candour for both LCHS and ULTH. The Committee were advised that progress against plans continued to be on track with audit briefs for all Q1 and Q2 audits commenced.

The Committee were advised that of the 32 legacy audit recommendations which had been handed over to BDO, 14 had been closed at the last Committee meeting.

A further 5 had been closed since the last Committee. The Committee were alerted to the fact that the remaining 13 would fall due before January Committee and a process was being agreed to manage following these up with leads.

The Committee agreed that remaining actions would also be shared through Executive Leadership Team meeting and Board Committees to maintain the focus.

The Committee received the Essential Standard report which confirmed BDO's compliance in line with Global Internal Audit Standards requirements.

The Committee received the Duty of Candour Internal Audit Reports which offered Moderate assurance for control design and effectiveness for both organisations. It was agreed that both People and Quality Committee would further review the report findings.

The Committee received the LCFS Progress Report for both organisations. The report included the Staff Fraud Awareness Survey conducted in August 2026. The survey had been completed by 174 staff at LCHS and 384 staff at ULTH which was a lower rate than previous years. The Committee considered some specific issues highlighted in the report relating to NMC and delays with fitness to practice proceedings and how this was managed and impacted in the organisations.

The Committee received assurance in respect of the compliance with governance arrangements in the form of the quarterly compliance report. The report had been updated for all recent CQC activity and the Committee noted that waivers of standing orders continued to reduce. The Committee were advised of the issues behind a spike in the value of losses written off for the quarter. A slight improvement in Progress Living occupancy was reported. A write-off of pharmacy stock had been reviewed and processes updated to ensure the issue would not be repeated.
The Committee asked if an update could be provided in future reports of information governance breaches. This is reported through Finance and Performance Committee but would be captured in summary going forward.

The Committee considered the Board Assurance Framework and Risk Management Report noting that despite the continued work around risks which were outside of appetite, progress was limited.

The Committee received a report on the actions being taken to address the level of overdue policies. Whilst the considerable amount of work being completed centrally was acknowledged, the improvement trajectory had not been achieved and the Committee felt that assurance was limited. The Committee were advised of the process through which policy performance was being monitored. The Committee questioned whether the PRM process was effective in addressing the ongoing challenge and improvement. The Committee also discussed how policy management moving into single organisation was being reviewed and sought further assurance that plans were in place for all critical policies to be unified by the 1 April 2027.

The Committee received triangulation of compliance from assurance committee chairs. The Committee considered the pressures on corporate teams supporting the transformation and change which had been highlighted through Committees.

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

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

a) Improvement in the overdue policy position
b) Assurance on policies requiring review ahead of move to single organsiation

4.0 Matters for reporting / escalation to the Group Board

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

a) Continued performance below trajectory of policy management

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

5.1 The committee considered the BAF and Risk Register and gave increased oversight to the movement by month in the report of assurance ratings and risks which were rated outside of agreed risk appetite. It was recognised that the BAF was being used well by Committees.

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

26 October 2026

Lincolnshire Community and Hospitals NHS Group
Board Work Programme 2026/27

Agenda Item	Lead	Person Responsible	Committee Oversight	May	Jul	Sep	Nov	Jan	Mar	Purpose of Report	Action
Business Items											
Public Questions	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X		
Ward Accreditation	Group Chief Nurse		N/A	X	X	X	X	X	X		Assurance
Declarations of Interest	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	To note any conflicts of interest on specific agenda items or any changes to Directors' Interests	Assurance
Annual Declaration of Board Interests	Group Chair	Group Director of Corporate Affairs	N/A	X						To review and note any changes to the Register of Directors' Interests	Assurance
Fit and Proper Person Annual Declaration	Group Chair	Group Director of Corporate Affairs	Audit & Risk Committee	X						To receive assurance that all board members remain compliant with the Fit & Proper Person requirements	Assurance
Minutes of the previous meeting	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained	Approval
Matters arising from the previous meeting/action log	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X	To ensure all agreed board actions are completed	Assurance
Group Chief Executive Report to the Board	Group Chief Executive	Executive Business Manager	N/A	X	X	X	X	X	X	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	
Celebrating Group Success	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A		X		X		X	To hear from Clinical Teams and give clinical teams access to the Board	
Patient/staff Story	Group Chief Nurse	Associate Director of Communications and Engagement	N/A	X		X		X		To receive direct feedback on the experience of both patients and staff	
Patients											
Strategic Aim 1 - High quality, timely care in the right place											
Assurance and Risk Report from the Quality Committee	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Quality Committee Annual Report	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Quality Committee ToR and Work Programme	Chair of Quality Committee	Deputy Trust Secretary	Quality Committee	X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Safeguarding Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee			X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Infection Prevention and Control Annual Report	Group Chief Nurse	Deputy Director of Infection Prevention and Control	Quality Committee			X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Complaints Annual Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Quality Committee			X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Patient Experience Annual Report	Group Chief Nurse	Group Director of Safeguarding and Patient Experience	Quality Committee			X				To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Assurance and Risk Report from the Finance Committee	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Finance Committee Annual Report	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Finance Committee ToR and Work Programme	Chair of Finance Committee	Deputy Trust Secretary	Finance Committee	X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Financial Plan	Group Chief Finance Officer		Finance Committee							To approve the Financial Plan	Approval
Capital Plan	Group Chief Finance Officer		Finance Committee							To approve the Capital Plan	Approval
Contract Award Reports	Group Chief Finance Officer	Deputy Director of Procurement	Finance Committee	X	X	X	X	X	X	To approve relevant Contract Awards in accordance with the Trusts' Schemes of Delegation	Approval
Emergency Preparedness Annual Report and EPRR Core Standards	Group Chief Estates and Facilities Officer	Emergency Planning and Business Continuity Manager	Finance Committee				**X (def. from July)**			To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Assurance
People											
Strategic Aim 2 - Attract and retain talent, build a strong culture											
Assurance and Risk Report from the People Committee	Chair of People Committee	Deputy Trust Secretary	People Committee	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
People Committee Annual Report	Chair of People Committee	Deputy Trust Secretary	People Committee	X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
People Committee ToR and Work Programme	Chair of People Committee	Deputy Trust Secretary	People Committee	X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Gender Pay Gap Report	Group Chief People Officer	Director of People	People Committee						X	To receive the Gender Pay Gap Report	Assurance
Ward Establishment Review	Group Chief Nurse	Deputy Director of Nursing and Midwifery	People Committee			**X (def. from May)**			X	To approve the outcome of the review of safe staffing and any recommended changes to the establishment	Approval
Responsible Officer Revalidation Report	Group Chief Medical Director	Deputy Medical Director	People Committee			X					
National Staff Survey Results	Group Chief People Officer	Director of People	People Committee	X					X	To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements	Assurance
FTSU Annual Report	Group Director of Corporate Affairs	FTSU Guardians	People Committee				**X (def. from July)**			To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Equality Delivery System Report	Group Chief People Officer	Director of People	People Committee	X					X	To approve the annual EDS submission	Approval
Workforce Race Equality Standard (WRES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee			X				To approve the annual WDES submission	Approval
Workforce Disability Equality Standard (WDES) Report and Action Plan	Group Chief People Officer	Director of People	People Committee			X				To approve the annual WDES submission	Approval
Population Health											
Strategic Aim 3 - Adapting to neighbourhood health needs											
Assurance and Risk Report from the Integration Committee	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee	X	X	X	X	X	X	To note the matters considered by the committee and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Integration Committee Annual Report	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee	X						To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Integration Committee ToR and Work Programme	Chair of Integration Committee	Deputy Trust Secretary	Integration Committee	X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
Risk and Assurance											
Integrated Performance Report	Group Chief Integration Officer	Associate Director of Performance and Information	Finance Committee	X	X	X	X	X	X	To brief the boards on key performance metrics & priorities, risks to delivery & mitigations	Assurance
Group Risk Management Report	Group Chief Clinical Governance Officer	Deputy Group Chief Clinical Governance Officer	Audit & Risk Committee	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Board Assurance Framework	Group Director of Corporate Affairs	Deputy Trust Secretary	Audit & Risk Committee	X	X	X	X	X	X	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the Trusts' current risk profile	Assurance
Strategic Objectives	Group Chief Integration Officer	Director of Strategy and Planning							X	To approve the Group Vision, Strategy & Objectives	Approval
Assurance and Risk Report from the Audit Committee	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X		X	X		X	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Assurance
Audit Committee Annual Report	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee				X			To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Assurance
Audit Committee ToR and Work Programme	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X						To approve the changes to board committee terms of reference and work plans following annual review.	Approval
NHS Provider Licence Self Certification	Chair of Audit Committee	Group Director of Corporate Affairs	Audit & Risk Committee	X						To agree the annual Trust Board self certification of compliance with the NHS Provider Licence	Approval
Year End Accounts and Annual Report	Chair of Audit Committee	Group Chief Finance Officer/ Group Director of Corporate Affairs	Audit & Risk Committee		X					To approve and adopt the Annual Report & Accounts	Approval
End of meeting											
Board Work Programme	Group Director of Corporate Affairs	Deputy Trust Secretary	N/A	X	X	X	X	X	X	To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements	Assurance
Any other notified items of urgent business	Group Chair	Group Director of Corporate Affairs	N/A	X	X	X	X	X	X		