Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING - 7 AUGUST 2025

BOARD OF DIRECTORS MEETING - 7 AUGUST 2025

7 August 2025

09:15 GMT+1 Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

- Patient Story from the Medical Division (09.15am) 1
- Agenda 2

0.0 - Agenda - Board (part I) - 7 August 25 .pdf 3

1. Chair and quorum (09.30am) 5
2. Apologies for absence (09.31am) 6
3. Declaration of interests (09.32am) 7
4. Minutes of the previous meeting held on 3 June 2025 (09.33am) 8

4.0 - Minutes - Board (Part I) - 3 June 25 - approved.pdf 9

5. Matters arising and action log update (09.34am) 24

5.0 - Action log - Board (part I) - 3 June 25.pdf 25

6. Chair's opening remarks and report (09.35am) 27

6.0 - Chairs Report - 7 August 2025.pdf 28

7. Chief Executive's Report (09.40am) 33

7.0 - Chief Executive's report.pdf 34

8. Board Assurance Framework (09.50am) 43

8.0 - BAF Risk Paper - Aug 2025 - Final.pdf 44

9. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY) 74

9.1 Safety and Quality Committee Chair's Report (10.00am) 75

9.1 - Chair's report - Safety and Quality Committee - 30 May 2025 & 27 June.pdf 76

9.2 *Quality Account (10.10am) 83

9.2 - Quality Account -August 2025.pdf 84

9.3 *Annual Safeguarding Report (10.15am) 86

9.3 - Safeguarding Annual Report 2024-25 Final BOD.pdf 87

9.4 *Maternity and Neonatal Services (10.20am) 91

9.4 - Maternity and Neonatal Safety Report - July 2025 for August Board Executive summary.pdf 92

9.5 Winter Planning ? Lesson Learnt and Planning 25/26 (10.30am) 96

9.5 - Winter Planning Paper 2425 .pdf 97

10. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH) 105

10.1 Workforce Committee Chair's Report (10.40am) 106

10.1 - WFC Chair's Report - 8 July 2025.pdf 107

10.2 *Guardian of Safe Working report (10.50am) 111

10.2 - GOSW Annual Report 2024 for Board FINAL.pdf 112

10.3*Social Value Strategy (10.55am) 116
10.3 - Social Value Strategy .pdf 117
10.4Education, Training and Research Committee Chair's Report (11.00am) 120
10.4 - Chair's report - Education Training and Research Committee 10 June 2025.pdf 121
• Break (11.10am) 124
11. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE) 125
11.1Integrated Performance Report (11.25am) 126
11.1 - Integrated Performance Report as at 30 June 2025.pdf 127
11.2Finance and Performance Committee Chair's Report (11.45am) 168
11.2 - Chair's report - FPC - 27 May & 24 June 2025.pdf 169
12. RISK, GOVERNANCE AND COMPLIANCE 175
12.1Audit Committee Chair's Report (11.55am) 176
12.1 - Audit Chair's Report - 24 June 2025.pdf 177
12.2Charitable Funds Committee Chair's report (12.05pm) 180
12.2 - Charitable Funds Committee Chairs Report - 17 June 2025 - approved.pdf 181
12.3EPRR Core Standards Assurance (12.15pm) 184
12.3 - EPRR Core Standards Annual Assurance 2025-2026.pdf 185
13. ITEMS FOR INFORMATION 209
13.1AHP Safe Staffing Report 210
13.2Date, time and venue of next meeting: (12.25pm) 211

PATIENT STORY FROM THE MEDICAL DIVISION

Information Item

09.15am

AGENDA

REFERENCES

Only PDFs are attached

0.0 - Agenda - Board (part I) - 7 August 25 .pdf

Board of Directors

7 August 2025 | 09.15am | Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

At 09.15am, there will be a **patient story from the Medical Division.**

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9:30am	Verbal	Information	M Thomas
2.	Apologies for absence	9:31am	Verbal	Information	M Thomas
3.	Declaration of interests	9:32am	Verbal	Information	M Thomas
4.	Minutes of the meeting held on 3 June 2025	9:33am	✓	Decision	M Thomas
5.	Matters arising and action log update	9:34am	✓	Decision	M Thomas
6.	Chair's opening remarks and report	9:35am	✓	Information	M Thomas
7.	Chief Executive's report	9:40am	✓	Information	S Nicholls
8.	Board Assurance Framework	9:50am	✓	Decision	S Regan
9.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
9.1	Safety and Quality Committee Chair's Report – *following 2 reports are also recommended for approval confirmation*	10.00am	✓	Assurance	K Deeny
9.2*	Quality Account	10:10am	✓	Decision	H Ugradar
9.3*	Annual Safeguarding Report	10:15am	✓	Decision	S Morrison
9.4*	Maternity and Neonatal Services	10:20am	✓	Assurance	S Morrison
9.5	Winter Planning – Lesson Learnt and Planning 25/26	10:30am	✓	Assurance	K Foster-Greenwood
10.	**GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)**				
10.1	Workforce Committee Chair's Report - *following 2 reports are also recommended for approval confirmation*	10.40am	✓	Assurance	A Leather
10.2*	Guardian of Safe Working report	10.50am	✓	Decision	N Pease
10.3*	Social Value Strategy	10:55am	✓	Decision	N Pease
10.4	Education, Training and Research Committee Chair's Report	11.00am	✓	Assurance	S Crean

№	Item	Time	Encl.	Purpose	Presenter
BREAK		11:10am			
11.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
11.1	Integrated Performance Report as at 30 June 2025 including Finance update and Single Improvement Plan *(considered by appropriate Committees of the Board)*	11.25am	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ C Carter
11.2	Finance and Performance Committee Chair's Report	11.45am	✓	Assurance	A Leather
12.	**RISK, GOVERNANCE AND COMPLIANCE**				
12.1	Audit Committee Chair's Report	11:55am	✓	Assurance	T Wheeler
12.2	Charitable Funds Committee Chair's report	12:05pm	✓	Assurance	T Ballard
12.3	EPRR Core Standards Assurance	12:15pm	✓	Decision	K Foster-Greenwood
13.	**ITEMS FOR INFORMATION * ancillary pack**				
13.1*	AHP Safe Staffing Report *** Full Report in ancillary pack**		✓		
13.2	Date, time and venue of next meeting: *2 October 2025 at 9:15 am at Lecture Room 1, EC1 Royal Preston Hospital*	12:25pm	Verbal	Information	M Thomas

* Full Report in ancillary pack

1. CHAIR AND QUORUM

Information Item | M Thomas | 09.30am

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 09.31am

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 09.32am

4. MINUTES OF THE PREVIOUS MEETING HELD ON 3 JUNE 2025

Decision Item | M Thomas | 09.33am

REFERENCES

Only PDFs are attached

4.0 - Minutes - Board (Part I) - 3 June 25 - approved.pdf

Board of Directors

3 June 2025 | 9.15am
Lecture Hall, Educations Centre 3, Chorley and South Ribble Hospital.

Part I

Present:

Professor M Thomas	Chair
Dr T Ballard	Non-Executive Director
Mr C Carter	Interim Chief Finance Officer
Dr K Deeny	Non-Executive Director
Ms K Foster-Greenwood	Chief Operating Officer
Professor S Nicholls	Chief Executive Officer
Mr U Patel	Non-Executive Director
Mr J Schorah	Non-Executive Director
Professor T Wheeler	Non-Executive Director

In attendance:

Mrs A Brotherton	Chief Strategy and Improvement Officer
Mrs J Foote	Director of Corporate Affairs
Ms L Graham	Deputy Chief People Officer
Ms C Gregory	Deputy Chief Nursing Officer *(staff story and item 108/25)*
Dr N Pease	Chief People Officer
Mr S Regan	Associate Director of Risk and Assurance
Mrs J Wiseman	Interim Business Manager, Corporate Affairs *(minutes)*

Governors observing: Margaret France, Christine Pownall, Darrell Brooks, Frank Robinson, Paul Brooks, Sonia Connell, Janet Miller, Carole Oldcorn, Enid Povey.

Observers: Raj Purewal, C2-Ai
Annemarie Vicary, National Recovery Support Team, NHSE
Joe Roberts, Good Governance Institute

Prior to the meeting the Board received the following presentation: Staff Story, Discharge Lounge.

Lynn's journey began in 2020 when she was admitted as a patient to Royal Preston Hospital. Following her treatment, she returned to work as a stoma user, a transition that initially presented significant challenges. At the time, there were no reasonable adjustments in place, particularly regarding toilet facilities, which were not stoma-user friendly. Determined to make a difference, Lynn engaged with the Patient Experience Lead to share her insights and propose improvements. Collaborating with the Stoma Nurse and colleagues in the Estates Division, Lynn helped drive meaningful change. As a result, the Trust now had stoma-friendly toilets, complete with inclusive signage highlighting that not all disabilities were visible and practical features such as user-friendly shelving.

Lynn's line manager played a pivotal role in amplifying her voice and ensuring that reasonable adjustments were made to support her wellbeing at work. Lynn also contributed to the development

of patient information leaflets, working closely with the stoma care team to ensure they reflected real-life experiences.

In her message to the Board, Lynn emphasised the importance of listening to colleagues with lived experience and recognising how small, thoughtful changes can significantly improve the experience of both staff and patients facing adversity. Although Lynn was unable to attend the Board meeting in person, it was suggested that she be invited to share her story at a future All Colleagues Team Briefing session. Her experience highlighted the strong collaboration between workforce colleagues, patients and the Patient Experience Team in driving improvements across the Trust.

94/25 Chair and quorum

Having noted that due notice of the meeting had been given to each member and that a quorum was present the meeting was declared duly convened and constituted.

The Board of Directors were informed that the meeting would be observed by representatives from the Good Governance Institute and National Recovery Support Team.

95/25 Apologies for absence

Apologies for absence were received from Mrs S Morrison, Dr G Skailes, Mr A Leather and Professor S Crean.

96/25 Declaration of interests

Non-Executive Dr T Ballard declared an interest in that he was a CQC National GP Advisor. The interest was noted with no requirement to leave the meeting.

97/25 Minutes of the previous meeting

The minutes of the meeting held on 3 April 2025 were approved as a true and accurate record.

98/25 Matters arising and action log

There were no matters arising and the updated action log was received.

99/25 Chair's report

The report provided a summary of work and activities undertaken during April and May 2025 by the Trust Chair including a resumé of the items discussed in the part II Board meeting in April.

100/25 Chief Executive's report

The report provided an overview on matters of interest since the previous meeting. In addition, the Chief Executive highlighted some key points.

Nationally, the NHS Pay Award for 2025/26 had been confirmed, with implications for various staff groups and organisational finances. Additionally, the British Medical Association had announced its intention to ballot resident doctors for potential industrial

action from July 2025 to January 2026, which could significantly impact elective and cancer care recovery efforts. A discussion was held around the implications of the national pay award. While the award was welcomed, it was noted that the financial impact remained under review due to the complexity of the pay structure and the variation in staff distribution across the grades. The Trust anticipated a potential cost pressure and had committed to updating the Finance and Performance Committee once a full assessment had been completed.

The Trust had welcomed an interim Chief Finance Officer and the upcoming retirement of the Chief Medical Officer was noted. Recruitment for the successor had attracted strong interest, with interviews scheduled for late June. The recruitment process had been managed internally using a micro-site and existing networks, resulting in cost savings and a more diverse candidate pool.

Financially, the Trust had identified £60million in savings for the year, though a portion had high risk associated with it. Careful balance was required to become financially sustainable, deliver the service and maintain patient safety and experience. The inter-site shuttle bus service between Royal Preston and Chorley hospitals ceased operation at the end of May due to cost pressures and limited usage.

Strategic service developments included the planned centralisation of vascular services at the Royal Preston Hospital site, with implementation expected towards the end of 2025. This was an important decision that would support the work for major trauma and tertiary centre. A single clinical team would work collaboratively, delivering outpatient and daycase services across Lancashire and South Cumbria. The Trust had also been confirmed as the host for the new single pathology service across Lancashire and South Cumbria, with the aim of forming a single team providing a unified service by Autumn 2025. Throughout this period, the Trust remained committed to engaging with staff and key stakeholders, including staff side representatives.

Further service reviews across the system were underway, including stroke, head and neck and neurology services, with a focus on clinical and financial sustainability. The Trust continued to work closely with community and primary care partners to address pressures in urgent and emergency care, including the recent transfer of community dietetics services.

The Board noted the Trust's dual strategic priorities: achieving financial sustainability and improving the quality of care, with the aim of progressing from the 'Requires Improvement' to a 'Good' CQC rating. It was emphasised that while financial recovery remained a key focus, the Trust continued to prioritise patient safety and care standards.

It was confirmed that the Finance and Performance Committee had oversight of the £60m identified Waste Reduction Programme and the Improvement and Assurance Group meetings remained in place.

A question was raised around the Chief People Officer who had recently taken on a joint role with a neighbouring Trust. This arrangement aimed to enhance leadership value across the system and support the increasing integration of services. The joint role was also seen as an opportunity for reciprocal learning and leadership development across both organisations.

The importance of robust equality and quality impact assessments was highlighted, particularly in the context of ongoing service changes. The Trust had embedded these assessments into its bi-weekly delivery meetings, ensuring that financial decisions were balanced against safety and quality considerations. A recent example included the decision not to proceed with home delivery of chemotherapy due to patient safety concerns.

The Board acknowledged the achievements of several clinical areas that had attained the Gold STAR audit accreditation. It was agreed that a formal note of recognition would be sent to those teams in appreciation of their contribution.

101/25 Board Assurance Framework

The Board received an update on the Board Assurance Framework (BAF), following the Board workshop held on 6 May 2025. The update included a summary of changes to principal risks, alignment with the 2025/26 corporate objectives and a review of the Trust's risk appetite and tolerance. It was noted that the score for Principal Risk 2, relating to Clostridium Difficile infection rates, had been reduced from 20 to 16 due to improved performance in 2024/25. Target control dates had been added to all principal risks and assurance levels were now categorised in line with internal audit recommendations.

The Board considered and approved the development of a new principal risk relating to timely access to diagnostic investigations, aligned with Corporate Objective 8. A draft of this risk was included for review and would be monitored by the Finance & Performance Committee.

The Board also noted the closure of historic strategic risks, with the remaining action transferred to Principal Risk 15, research capacity and capability. No operational high risks were escalated this month.

A review of the Trust's risk appetite and tolerance had been undertaken. The Board had reviewed a change in the risk appetite for the 'Productivity' strategic objective from 'open' to 'cautious', reflecting the current financial operating environment and regulatory expectations.

Board members also raised concerns regarding the presentation of principal risks, particularly those with persistently high scores. It was suggested that some risks may be driven by a small number of high-impact components and that identifying those could provide a clearer picture of where the greatest challenges lay. While it was acknowledged that the current format offered targeted focus, the Board agreed that further refinement could enhance understanding of risk tolerance. The current focus was on embedding the risks into operational delivery and ensuring that actions were aligned with intended outcomes. In response to a query on assurance, it was confirmed that trajectory timelines had been introduced for each principal risk. Further work was underway to clarify which actions were within the Trust's control and which required system-level support. Urgent and Emergency Care (UEC) was cited as an example where external dependencies needed to be more clearly articulated and escalation routes strengthened.

The Board RESOLVED to approve the:

1. **updates in the Board Assurance Framework and action plan for the historic strategic risks.**
2. **newly identified Principal Risk relating to Timely Access to Diagnostics for oversight at Finance & Performance Committee.**
3. **Risk Appetite, Risk Tolerance and Revised Risk Appetite Statement.**

102/25 Safety and Quality Committee Chair's Report

It was explained that the Board was introducing a more streamlined approach to handling reports. Instead of repeating presentations already reviewed by Committees of the Board, the chair of those Committees would now confirm whether appropriate scrutiny had taken place. Full reports were still available in an ancillary pack and the Board would focus on decision-making rather than duplicating reviews.

The Board received a verbal update from the Chair of the Safety and Quality Committee, supplementing the written report covering the March and April meetings. The update included key developments from the most recent meeting held on the 30 May 2025.

The Board was alerted to a recently reported never event within the theatre service. The incident had been appropriately escalated and reported through national patient safety systems, including the Patient Safety Incident Response Framework (PSIRF) and relevant external bodies had been informed. As this was another 'never event' in the same service, a two-week pause in theatre activity was implemented to allow for a comprehensive internal review. A forensic review was scheduled to be completed by the end of the month and an external review was also being arranged in collaboration with the relevant professional body.

The Board was also advised of progress in maternity services, where a reconfiguration of Tier 2 staffing had been successfully implemented. This change not only improved service delivery but also contributed to financial stability.

It was noted that a decline in the STAR audit accreditation ratings had been anticipated due to raised standards. However, improvements were expected from August, reflecting the Committee's increased focus on setting clear timeframes and trajectories for improvement. The Committee had planned a deep dive into care for boarded patients at its next meeting, recognising the complexity of this area. Additionally, the establishment of a dedicated health and safety workstream within the Trust's single improvement group had been endorsed. The Board was informed of national recognition for the application of the Getting It Right First Time (GIRFT) framework within children's services.

Furthermore, the Committee had received assurance regarding recent facilitation work undertaken in maternity services. The Board was informed of a recent maternal death that occurred on the Maternity Unit. The incident was described as a tragic and rare event. A visit to the unit had been undertaken by the Board's Non-Executive Director Safety Champion and this provided an opportunity to engage directly with staff and assess the response. A rapid review was undertaken immediately following the incident and the case had been appropriately reported through the National Maternity Reporting System in line with statutory obligations. It was confirmed that there were no concerns regarding the quality of care provided and the coroner subsequently determined the cause of death to be natural causes. The emotional impact on staff was noted to be significant and the Board formally acknowledged the professionalism and compassion

demonstrated by all those involved in the care of the patient and her baby. A letter of gratitude had been received from the family, recognising the exceptional care provided across maternity, neonatal intensive care, theatres and critical care services. The Board extended its sincere condolences to the family and expressed its appreciation and support to the staff affected by the incident.

The importance of applying both detailed and thematic approaches for safety and quality assurance was noted. In addition to the deep dives following individual incidents, the Board emphasised the need to adopt a broader, long-term view to identify recurring patterns or systemic issues across services, departments, or individuals. This included triangulating data from complaints, patient experience, workforce feedback, and Freedom to Speak Up (FTSU) concerns. It was confirmed that this wider lens was embedded in the work of the Safety and Quality Committee, with a focus on correlating insights across multiple data sources. The Board was assured that this approach aligned with the Patient Safety Incident Response Framework (PSIRF), which promoted system-level learning over isolated case reviews.

The Board also noted ongoing efforts to align FTSU processes with clinical safety oversight. While FTSU traditionally focused on workplace concerns, work was underway to distil and integrate relevant clinical safety themes into broader assurance mechanisms. A dedicated Non-Executive Director had been appointed to oversee FTSU and further alignment with the Safety and Quality Committee was planned.

103/25 Infection, Prevention and Control Annual Report

The report provided an overview of the progress made against the Infection Prevention and Control plan for 2024/2025 and assured the Board of Directors on the Trust's performance against key areas of Infection Prevention and Control (IPC). The Safety and Quality Committee had endorsed the Infection Prevention and Control Annual Plan for 2025/26 at its 30 May 2025 meeting *(minute ref 92/25).*

The Board noted a reduction in Clostridium Difficile cases, with 192 recorded against a tolerance level of 199. Despite this, the Trust remained the second highest in the region. Implementation of national cleaning standards had shown statistically significant improvements and further investment had been retained in the financial plan. Full implementation would take a year, with prioritisation based on clinical risk. The ageing estate, including sewage infrastructure and limited side room capacity, remained key challenges. A business case had been submitted to NHS England for capital investment. The Board requested benchmarking against similar trusts with older estates but lower infection rates. This would be progressed through the Safety and Quality Committee.

The Board RESOLVED to confirm its assurance of the progress against the 2024/25 Annual Plan and approved the IPC Annual Plan for 2025/2026.

104/25 Patient Experience Annual Report

The Safety and Quality Committee had reviewed the Patient Experience Annual Report and acknowledged the significant work involved. It had been noted that quantifying patient experience remained a challenge due to its qualitative nature. However, the importance of incorporating measurable elements was emphasised. The Committee had endorsed the report and recommended it for Board approval (minute ref 94/25).

The Board RESOLVED to approve the Patient Experience Annual Report and Action Plan.

105/25 Patient Safety Incident Response Framework Annual Report

The Safety and Quality Committee had reviewed and endorsed the Patient Safety Incident Response Framework Annual Report (PSIRF) at its meeting held on 30 May 2025 (minute ref 91/25). Future reporting would include the correlation between PSIRF and the Waste Reduction Programme. The implementation and impact of the recently published NHS England 'Being Fair' tool had also been considered for how the guidance would impact patient involvement in incidents. This would also be considered as a future topic for a Board Workshop.

The Board heard that there was a system-wide learning forum across the ICB, involving trusts across Lancashire and South Cumbria. Opportunities to share learning more broadly, including at national level, were being explored. Regular national forums were now in place, providing a platform to showcase organisational learning and promote wider dissemination of best practice. The Trust remained committed to contributing to and benefiting from these collaborative efforts.

The Board confirmed its assurance of the Patient Safety Incident Response Framework for the management of incidents.

106/25 Quality Account

The Board received a presentation on the draft Quality Account 2024–2025. The report outlined key achievements and areas for improvement across patient safety, clinical effectiveness, patient experience, staff engagement and innovation.

A question was asked on how the Trust could be sure that the reduction in complaints was due to early resolution and if there were any barriers that hindered the complaints process. It was explained that the reduction in formal complaints appeared to correlate with an increase in early resolution of concerns and enquiries. These were logged differently, suggesting that early resolution was effective in addressing issues before they escalated to formal complaints. A suggestion was made to cross-reference compliments with workforce experience. It was explained that while theme analysis of compliments had not yet been fully developed, the Trust had been encouraging the logging of compliments and there were plans in place to build this into future analysis.

A discussion was held around the Freedom to Speak Up (FTSU) pathway and if there were any barriers. The FTSU champions within the organisation were accessible for staff which provided assurance however, further work was going to be undertaken to strengthen staff engagement.

The approach taken for the draft Quality Account was endorsed, noting that the document would undergo further consultation and scrutiny by the Safety and Quality Committee before final Board approval and publication.

107/25 Workforce Committee Chair's report

The Chair's report from the Workforce Committee provided an overview of items discussed at the meetings on 12 May 2025 based on the 3As methodology (Alert,

Advise, Assure) including, where appropriate, items recommended for approval by the Board. A discussion was held around the alert item for workforce planning capacity. In the long term, there would be resilience through the relationship with One LSC and digitisation. However, for this financial year, there was a risk which was only partly mitigated by planned actions. It was noted that most organisations were finding workforce information increasingly challenging due to a surge in demand over the past year. In response, efforts were being made to adopt best-in-class solutions such as automated data flows to replace manual processes.

108/25 Workforce Race Equality Standard (WRES) Report 2025 and Workforce Disability Equality Standard (WDES) Report 2025

The Board received the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports for approval ahead of external publication and submission to NHS England. It was confirmed that both reports had been reviewed and endorsed by the Workforce Committee in May *(minute ref 59/25).* The WRES report highlighted improvements in equal opportunities and reduced bullying from the public and colleagues among ethnic minority staff. However, concerns remained around shortlisting disparities, board-level representation and experiences of discrimination from managers and colleagues.

The WDES report showed progress in representation, adequate and reasonable adjustments for disabled staff and reduced pressure to work when unwell. Nonetheless, disabled colleagues continued to report higher levels of bullying and harassment, particularly from patients, managers and colleagues. Colleagues with disability had lower satisfaction with feeling valued by the organisation.

Both reports included targeted action plans aligned with NHS England's high-impact actions and the Trust's Equality, Diversity and Inclusion Strategy.

A question around international recruitment opportunities was asked to understand if there was an alternative approach. It was confirmed that international recruitment had been completed for the moment. The next step would be to ensure these colleagues, particularly those from ethnic minority backgrounds and other protected groups, were supported through leadership and management development programmes. Concerns were raised about potential changes to citizenship pathways and it was agreed that longer term plans would be explored by the Workforce Committee. It was suggested that the experience of an internationally recruited colleague could be shared as a staff story.

A question was asked around the support to prepare for interviews for candidates with protected characteristics who were applying for roles within the Trust. It was explained that the Head of Equality, Diversity and Inclusion was working with the recruitment team to review the recruitment pathway to remove areas where there could be adverse impact. This included a review from a social value lens that removed references to class or privilege. Further actions to remove bias in recruitment were underway that would be reported in the Recruitment Strategy received by the Workforce Committee. The number of colleagues who were now declaring long term conditions and implementing supporting disability agreements as part of an appraisal had increased. It was agreed to work on key messages to help colleagues understand how the work on reasonable adjustments and support for colleagues helped to reduce overall sickness rates. In terms of access to work and sourcing equipment for adaptations, work was ongoing with procurement to stock some of the more frequently requested items.

The Board RESOLVED to approve the Workforce Race Equality Standard (WRES) Report 2025 and Workforce Disability Equality Standard (WDES) Report 2025 for external publication and submission to NHS England.

109/25 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee provided an overview of items discussed at the meeting on 8 April 2025. It was noted that four areas of dental training remained non-compliant, though significant improvements in overall training compliance had been achieved following the introduction of new reporting tools. The Committee had discussed the potential for reporting core training compliance through the Workforce Committee in future. Assurance was provided regarding progress in the National Education and Training Survey. The Trust's research activity, including increased income and investment through biotech partnerships and cancer trials had been acknowledged. The Committee had also highlighted ongoing work to address mandatory training compliance in specific divisions.

110/25 Integrated Performance Report as of the end of April 2025

The Board received an update on the Single Improvement Plan. It was confirmed that the Year 1 plan for 2024/25 had been delivered, with 14 of the 25 exit criteria achieved and one deemed no longer applicable due to the vacancy freeze. The remaining 10 metrics were recognised as challenging to meet outright, with a shift in focus towards demonstrating sustained improvement. Areas of continued concern included operational performance and workforce measures, particularly staff engagement and patients not meeting criteria to reside. For the Year 2 approach for 2025/26 feedback had been received from various stakeholders. A plan had been aligned to the Trust's 5 P's Framework (Patients, Performance, People, Productivity and Partnership) with each portfolio lead reviewing prior year outcomes and identifying core actions to drive improvement within current financial constraints.

The integrated performance report as of the end of April 2025 provided an overview of key performance indicators.

(a) Operational Performance Summary – April saw modest improvement in urgent and emergency care (UEC) performance, with 4-hour waits rising to 70.6%, though still below the national average of 74.8%. Ambulance handover times improved, however, performance remained below national standards and high levels of patients with no medical criteria to reside continued to impact flow. The 12-hour length of stay in the Emergency Department increased slightly and 13.9% of patients remained in hospital without meeting criteria to reside. Boarding reduced to an average of 14 patients per day. It was noted that significant increases in referrals, acceptance rates and capacity were required to achieve the ambition of decompressing the Emergency Department. Efforts were focused on expanding the Hospital at Home model through enhanced collaboration with primary care and the North West Ambulance Service, with Care Connections supporting pre-conveyance diversion from late June. Same Day Emergency Care performance exceeded the 40% target for the third consecutive month. The Days Kept Away from Home programme had launched, aiming to reduce deconditioning and improve discharge processes through a strength-based approach. Early feedback from consolidated

cohort areas at Chorley and Preston indicated successful de-escalation of care needs. The Continuous Flow model had also been reintroduced, with early data showing improved admission timings from the Emergency Department.

Cancer performance remained mixed and the Faster Diagnosis Standard was expected to achieve target, while 31-day performance improved. However, 62-day performance remained below trajectory due to capacity constraints in theatres and oncology. Breast performance was anticipated to recover in June and July with interim options for mutual aid. Further work was under way to assess the optimal capacity for the gynaecological pathway and that was also linked to the obstetric pathway.

From a referral to treatment (RTT) perspective, 18-week performance in April fell short of the provisional 2025/26 target by just over 2%, with a 1% deterioration from the previous month. The number of 52-week waiters increased, although a small reduction was noted in 65-week breaches. The Trust remained committed to eliminating all 65-week breaches by the end of Q1. Deterioration was attributed to reduced insourcing linked to the Waste Reduction Programme and outpatient capacity shortfalls. Initiatives such as text reminders and patient-initiated follow-up had begun to reduce DNA rates, particularly in orthopaedics. Diagnostics performance for DM01 improved for the fourth consecutive month, reaching 63.2%, driven by additional capacity, improved access policies and improved utilisation. Performance remained fragile and below national targets, with key challenges persisting in echo, ultrasound, endoscopy, and CT. National and regional support had been secured to assist with cardiology and audiology capacity.

A query was raised regarding assurance mechanisms for supporting staff to work differently, particularly in the context of hospital-at-home models and integrated working across organisations. It was noted that while co-location and shared practices were in place, further qualitative assurance was needed. The importance of visibility across teams and systems, especially regarding patient records and handovers, was highlighted.

A discussion was held around the outstanding exit criteria actions and CQC actions. Assurance was sought on how these were being embedded into practice and monitored. It was noted that stronger alignment between risk score reduction and evidence of sustained improvement would be demonstrated. These would be reviewed through the IPR and single improvement metrics by the relevant assurance committees. It was noted that the Audit Committee would have the overall review for all elements.

(b) Consistently Deliver Excellent Care – The adult inpatient areas remained in a positive position with RN staff fill rates achieving 96% and HCA achieving 104%. The maternity fill rate position for registered midwives (RM) achieved 93% in month. The maternity support worker fill rate has improved from previous months now at 91%. Sickness and vacancy rates were affecting fill rates with temporary staffing used to maintain safe staffing levels. Improving patient experience remained a key focus. Targeted efforts were underway as part of the Urgent and Emergency Care (UEC) improvement plans and enhancements to inpatient pathways.

STAR audit standards exceeded targets, even after new mandatory criteria had been introduced to address underperformance. Though outcomes dipped in high-risk

areas, recovery soon followed. Disaggregated reporting improved oversight, and the framework remained a strong quality assurance tool. Mortality rates remained within expected parameters and pressure ulcer harm levels had reduced. Maternity declared full compliance with the 10 CNST standards in February 2025 and was now in year 6. Four CQC “Must Do” actions remained outstanding, primarily related to training and documentation.

A question was raised regarding the potential to incorporate a population health perspective into the Integrated Performance Report (IPR), specifically to better understand how health inequalities affected different groups within the population. It was confirmed that would be included in the IPR’s development programme.

(c) Great Place to Work – Work had been undertaken to improve HCA recruitment pathways, with emphasis on apprenticeships and alternative entry routes to support broader access. Recruitment efforts aligned with social value priorities to enhance local employment opportunities.

A new Attendance Management Policy launched on 12 May and was positively received. Early intervention measures led to 77 staff triggering support earlier than under the previous policy, enabling more timely assistance and aiming to reduce progression to long-term sickness. A paper was presented to the Trust Management Board outlining further interventions to support staff wellbeing. Measures included restricting overtime and bank work following sickness absence, introducing a two-week or one-month break depending on absence duration. A senior case review process was initiated for long-term sickness cases exceeding six months. Of 37 cases reviewed, 29 had defined outcomes, with the remainder under active planning. Line manager engagement was identified as a key factor in successful case resolution. Access to psychological therapies and treatment pathways had been expanded. Plans were in place to deploy an occupational therapist and recruit a musculoskeletal physiotherapist to support staff with workplace adaptations and physical health needs. Empactis the digital programme had been piloted in hotspot areas to standardise sickness management processes. The tool provided prompts and template documentation to support line managers in delivering consistent and timely interventions.

Core skills compliance improved, with efforts focused on addressing persistent non-compliance. All resuscitation training posts were filled, including redeployment of at-risk senior qualified staff. In-situ training was introduced to increase accessibility and senior clinicians were being held accountable for mandatory training completion.

The vacancy rate stood at 7.61%, above the 6% target. Recruitment was scrutinised to ensure posts were essential. Engagement with the ICB and NHS England regional team was ongoing to explore redeployment opportunities in light of national workforce reductions. Staff survey results indicated room for improvement in perceptions of the organisation as a place to work. Increasing staff engagement was identified as a key objective, with a focus on addressing employment-related concerns and improving the overall staff experience.

A question was raised regarding assurance around role-specific clinical training beyond the core skills dataset. It was noted that the organisation performed strongly in mandated and job-specific training, with compliance rates exceeding 95%. However, issues had been identified in some departments where compliance with

specific core skills was lower. These anomalies were under review and data was regularly reported to the Education, Training and Research Committee. It was acknowledged that while the affected groups may represent a small dataset, the implications could be significant. Efforts were ongoing to address reporting inconsistencies and ensure accurate reflection of training compliance.

A concern was raised regarding the recent increase in aggression incidents in the Emergency Department. Improved reporting practices and a new partnership with a regional mental health team were noted as key responses. Security staff had managed a significant number of high-level restraint cases, highlighting the complexity of patient needs. The trust's security approach was being recognised as good practice, with potential introduction for wider training. A recent placement of a senior police officer had also helped strengthen collaboration between police and trust staff. It was suggested that a future staff story could showcase this work.

Concerns were also raised about compliance in paediatric training, particularly where advanced training had not translated into basic compliance. It was explained that a paper with escalation measures was being prepared for Trust Management Board, reinforcing the link between training compliance and patient safety. A graduated approach was being adopted to encourage completion of mandatory training. The strong evidence linking attendance at mandatory training courses with improved patient safety and quality of care was noted.

(d) Deliver Value for Money – The Trust set a break-even financial plan for the year, based on two key assumptions: delivery of a significant waste reduction target and receipt of a deficit support fund via the Integrated Care Board. At the time of planning, there was an unidentified gap, which was phased evenly across the year in line with national guidance. In the first month, the actual deficit exceeded the planned figure, primarily due to unidentified waste reduction schemes. Despite this, there were positive observations in run rate performance. Agency spend on medics and nursing had reduced significantly compared to the same period the previous year and headcount had decreased, reflecting systematic reductions from the previous year's waste reduction programme.

There were 245 waste reduction schemes identified, valued at just over £60million. However, £25million of this remained at an early developmental stage. The focus was on progressing these into fully scoped projects. Approximately 90% of schemes were recurrent, indicating sustainability into future years. Key areas of focus included enhanced grip and control, discretionary spending and bank spend across nursing and medical staff. Work was underway to analyse shift volumes and pay rates across the region to inform further schemes. The capital plan increased to £31.9million, up £11.7million from the previous iteration, driven by successful national bids. These included £6.9million for constitutional standards (diagnostics, elective recovery, urgent and emergency care) and £4.8million for critical infrastructure support. Cash flow was being closely monitored. At the end of month one, the Trust held £5.8million in cash against a plan of £5.5 million. However, with a daily spend of £2.3 million, this equated to just over two days of operating cash, highlighting the need for ongoing vigilance.

The organisation demonstrated strong commitment to financial control while maintaining focus on quality and patient care. Further development of assurance

processes and forward-looking financial planning was underway to support strategic decision-making and prepare for future challenges.

A query was raised around the government announcement that had confirmed the national distribution of £700million in capital funding. Further guidance was awaited on how trusts could access funds which would likely use a bidding process. Separately, NHS leadership had outlined plans to reduce agency usage by 30%, with trusts expected to demonstrate progress.

Assurance was sought on delivery and monitoring of multiple improvement schemes. A fortnightly review group was in place to track progress, with emphasis on execution and accountability. The importance of correlating data across objectives and timelines was highlighted to improve clarity and assurance.

The Board confirmed it was assured in respect of the actions being taken to improve performance.

111/25 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee provided an overview of items discussed at the meetings on 22 April 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

Progress had been made in identifying financial requirements and implementation risks, though it was emphasised that the pace of delivery now needed to increase. Cash flow remained closely linked to programme delivery timelines. Incremental improvements had been observed in some areas, but further work was required to meet targets. The importance of real-time updates to the risk register and clarity on delivery timelines had been highlighted. Procurement challenges had been acknowledged, with an improvement plan presented to address accountability and governance.

It was confirmed that internal audit would be directed to review elements of grip and control to strengthen assurance. This work would be coordinated through the Financial Recovery Programme, with oversight maintained by relevant committee chairs to ensure delivery remained on track.

112/25 Audit Committee Chair's Report

The Chair's report from the Audit Committee provided an overview of items discussed at the meeting on 17 April 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

Procurement remained a concern due to a high number of derogations from standard procedures, as highlighted by external audit. Targets and mechanisms to improve compliance were under discussion, with potential for significant savings. Issues around role clarity within One LSC were expected to be resolved by the end of July, with progress to be reviewed at the next meeting.

The clinical audit programme was under way, with a focus on maternity, obstetrics, and urology. Workforce challenges, particularly sickness absence, had been discussed, with initiatives in place to reduce rates. Achieving sector-average absence levels could yield

substantial financial savings. Efforts to control agency and bank costs had been noted as encouraging.

Improvements in data consistency and its impact on patient outcomes were viewed positively. The committee would continue to monitor those areas and support ongoing compliance.

113/25 Risk Management Policy

The Risk Management Policy had been further reviewed and updated, taking into account feedback from the initial consultation in August 2024 and March 2025, as well as some updates following Mersey Internal Audit Agency (MIAA) feedback in recent audits of Risk Management and the Board Assurance Framework. The policy had been validated at Audit Committee in April 2025 and recommended for Board approval *(minute ref 32/25)*.

The Board RESOLVED to approve the Risk Management Policy.

114/25 Raising Concerns at Work (including Whistleblowing and Freedom to Speak Up)

The annual report on raising concerns at work, whistleblowing, and the Freedom to Speak Up initiative was discussed. It outlined progress against the strategic Freedom to Speak Up Plan and noted that reporting levels had stabilised and remained below national trends. This prompted reflection on whether improved internal handling of concerns might be reducing the need for formal reporting. Assurance was provided regarding the robustness of current processes, with a high rate of case resolution and minimal instances of reopened cases. The organisation aimed to use staff survey results to identify specific areas for targeted action, moving away from a broad-brush approach. It was highlighted that this was the first trust where a dedicated raising concerns group triangulated both hard data, like complaints and soft intelligence through investigations, to proactively identify emerging issues.

Leadership challenges in this area had been acknowledged, following the sad loss of the 'Freedom to Speak Up' Lead due to illness. Leadership had since stabilised and progress was being made. It was noted that the number of concerns raised had decreased by 56% compared to the previous year, potentially reflecting improved engagement and communication efforts. It was advised that the report had been reviewed by the Workforce Committee with no issues escalated to the Board.

115/25 Board Visibility Report

The report provided an overview of the approach to the Board Safety and Experience Programme for 2024/25 and outlined the plan for 2025/26.

It was noted that a previous engagement initiative involving the maternity and children's teams had been positively evaluated through a brief impact assessment. This assessment highlighted the value of structured engagement and was taken into account during the appointment of new Non-Executive Directors.

As a result, a new approach was outlined whereby NEDs would be formally linked with specific divisional teams. This would replace the previous model of unannounced visits to clinical areas. Instead, NEDs would establish ongoing relationships with their assigned divisions and conduct visits as appropriate. These visits would include

engagement with patients, relatives and staff. Corporate Affairs would maintain a record of all such visits. Additionally, NEDs would meet monthly to share insights and cross-reference any matters requiring further attention. Where necessary, issues would be escalated to executive colleagues or relevant committees.

The Board RESOLVED to formally accept the revised approach to the Board Visibility Safety and Experience Programme.

116/25 Items for information

The following reports were received and noted for information:

(a) Fit and Proper Persons' Test/Completion of Director Appraisals – Annual Report
(b) Maternity and Neonatal Services Update

117/25 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday 7 August 2025, 9:15am, Lecture Room 1, EC1, Royal Preston Hospital

The meeting closed at 12.42pm

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | M Thomas | 09.34am

REFERENCES

Only PDFs are attached

5.0 - Action log - Board (part I) - 3 June 25.pdf

Action log: Board of Directors (part I) – 3 June 2025

No Outstanding Actions

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	100/25	3 Jun 2025	***Chief Executive's report -*** The Board acknowledged the achievements of several clinical areas that had attained the Gold STAR audit accreditation. It was agreed that a formal note of recognition would be sent to those teams in appreciation of their contribution.	DCNO	7 Aug 2025	**Completed** **Update 7 Aug 2025:** CNO informed action completed.
2.	103/25	3 Jun 2025	***Infection, Prevention and Control Annual Report -*** The Board requested benchmarking against similar trusts with older estates but lower infection rates. This would be progressed through the Safety and Quality Committee.	S&Q NED CNO	7 Aug 2025	**Completed** **Update 7 Aug 2025:** Added to Safety and Quality Committee cycle of business.
3.	105/25	3 Jun 2025	***PSIRF Annual Report -*** The implementation and impact of the recently published NHS England 'Being Fair' tool had also been considered for how the guidance would impact patient involvement in incidents. This would also be considered as a future topic for a Board Workshop.	ADoS&L	7 Aug 2025	**Completed** **Update 7 Aug 2025:** Added to Board Workshop Topic list.
4.	108/25	3 Jun 2025	***WRES Report and WDES Report 2025 –*** ***a)*** Concerns were raised about potential changes to citizenship pathways and it was agreed that longer term plans would be explored by the Workforce Committee.	CPO DD of W/OD	7 Aug 2025 7 Aug 2025	**Completed** **Update 7 Aug 2025:** a. Added to Workforce Committee cycle of business. b. Workforce liaising with relevant colleagues. c. passed to workforce department.

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
			b) It was suggested that the experience of an internationally recruited colleague could be shared as a staff story. ***c)*** It was agreed to work on key messages to help colleagues understand how the work on reasonable adjustments and support for colleagues helps to reduce overall sickness rates.	DD of W/OD D of Comms	7 Aug 2025	

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 09.35am

REFERENCES

Only PDFs are attached

6.0 - Chairs Report - 7 August 2025.pdf

Board of Directors Report

Chair's Report			
Report to:	Board Of Directors – Part 1	**Date:**	07.08.2025
Report of:	Chair	**Prepared by:**	Mike Thomas, Chair
Part I	√	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide a summary of work and activities undertaken during June and July by the Trust Chair.

It is recommended that the Board receives the report and notes the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Chair's Report

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during June and July 2025.

At the time of writing the Trust is awaiting the publication of the acute providers "league table" which is due on Tuesday 22nd July. The Trust will be within the lower quartile based on our returns and the data matrix used to compile the table. It is the expectation that the Trust will address, as it is doing, all the issues which challenge our ambition to be a good to outstanding Trust and future published presentations will reflect improvement.

An update on improvements and progress will be provided within the CEO report and Board agenda papers. The Board express our thanks to colleagues who are committed to transforming and enhancing the quality of care, and financial stability, provided by the Trust.

2. Chair's Update – Summary of Key Items from Private Board (3 June 2025)

- Progress was noted on regional service reconfiguration, with emphasis on restoring the Trust's tertiary service position.
- The Trust formally entered the Recovery Support Programme and received positive feedback from NHS England on its financial sustainability efforts.
- A Regulation 28 notice regarding thrombectomy services was received; engagement with the coroner was planned.
- The Board approved development of a partnership agreement for integrating child and adult physical health community services.
- A strategic update was provided on the vascular services transformation.
- The Board approved LTH as lead provider for a single pathology service and endorsed development of a partnership agreement to support the transition.
- Updates were shared on the Waste Recovery Programme.
- Committee minutes and reports were received for information, including updates from Finance, Safety and Quality, Workforce, Audit, and LHS Board meetings.

3. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during February and March 2025.

Date	Activity
June 2025	
3rd	Board of Directors
5th	IAG Prep Meeting with Executive Team
5th	1:1 Non-Executive Director
5th	Good Governance Interview
10th	1:1 Director of Corporate Affairs
10th	LTH Improvement & Assurance Group
11th	Lancs & South Cumbria Provider Collaborative Briefing
11th	1:1 A Vicary, NHSE
11th	Bishop of Burnley
12th	Lancs & South Cumbria Provider Collaborative Formal Board
17th	Non-Executive Monthly Meeting
17th	1:1 NHSE Chief Executive
17th	1:1 Chief Executive
18th	1:1 Non-Executive Director
19th	1:1 NHSE North West Regional Director
19th	1:1 Lead governor
19th	VLOG filming for internal communications brief
19th	1:1 Non-Executive Directors
19th	1:1 Director of Communications & Engagement
24th	LTH/Chorley Council
24th	1:1 ICB Chair

24th	1:1 Non-Executive Director
24th	1:1 Managing Director, One LSC
25th	Chief Medical Officer Interview Process
26th	Regional Strategic Workforce Assembly
26th	Special Board – Annual Report
26th	1:1 Managing Director, Provider Collaborative
26th	1:1 Lead CEO, Provider Collaborative
July 2025	
1st	Chairs, Deputy Chair and Lead Governor meeting
1st	Governors and Non-Executive Directors
1st	Extraordinary Board
2nd	LTH Improvement & Assurance Group
3rd	One LSC Improvement & Assurance Group
15th	Non-Executive Monthly Meeting
15th	1:1 Director of Corporate Affairs
17th	1:1 Chief Executive
17th	1:1 Director of Communications & Engagement
17th	Good Governance Review
17th	1:1 Managing Director, One LSC
17th	1:1 H Mascie-Taylor, ICB Clinical Workstreams
21st	Mtg with W Streeting/L Hoyle (London)
22nd	Walkabout – Oncology, Rosemere, Neurosurgery

4. Financial implications

There are no financial implications associated with the recommendations in this report.

5. Legal implications

There are no legal implications associated with the recommendations in this report.

6. Risks

There are no risks associated with the recommendations in this report.

7. Impact on stakeholders

There is no impact on stakeholders associated with the recommendations in this report.

8. Recommendations

It is recommended that the Board received the report and notes the contents for information.

7. CHIEF EXECUTIVE'S REPORT

Information Item | S Nicholls | 09.40am

REFERENCES

Only PDFs are attached

7.0 - Chief Executive's report.pdf

Board of Directors' Report

Chief Executive's Report							
Report to:	Board of Directors			**Date:**	7 August 2025		
Report of:	Chief Executive			**Prepared by:**	N Duggan		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☐	**For information**	☒		

Executive Summary:

The purpose of this report is to update the Trust Board on matters of interest since the previous meeting.

The Board is requested to receive the report and note its contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

Fit for the Future: 10 Year Health Plan for England

Published on 3 July 2025, the Fit for the Future: 10 Year Health Plan for England sets out a 10-year vision to build a more preventative, personalised, responsive, and sustainable health and care system for England. It reflects extensive engagement with patients, staff, and system leaders, and is designed to complement existing commitments in the NHS Long Term Plan (published 2019). The overarching goal is to shift the system from treating illness to promoting health and wellbeing, with a focus on early intervention, equity, and patient empowerment.

This will be achieved through three radical shifts, including - hospital to community, analogue to digital and sickness to prevention.

A sustainable workforce is vital to delivering the plan's ambitions. It supports ongoing reform of recruitment, training, and retention practices, with a focus on skills development, leadership, flexible working, and staff wellbeing. The plan also highlights the importance of inclusive and compassionate workplace cultures, and of developing new roles and career pathways across the health and care system.

What the 10-Year plan means for our Trust

This plan is very much in line with the direction of travel of our Trust - for example our ambition to create a Preston Health Hub with our partners; the creation of our Clinical Diagnostic Hub (CDH); our work with Care Connexions and increasingly close relationships with community teams and services; our drive towards being a University Hospital Trust; our work to reduce inequalities (for example our work with prisoners and within maternity) and the creation of One LSC as a new way of delivering corporate services.

In terms of the people element of the plan, in addition to the All Colleague and Senior Leaders Team Briefs that are now well established, and all the work that our Organisational Development Team do on a day to day basis, we have also developed plans for an extensive programme of formal staff engagement to help us understand and respond to the challenges that staff are experiencing. We already have a very comprehensive staff development and reward and recognition programme in place to ensure that our workforce is fit for the future whilst remaining motivated despite the intense financial and performance challenges we are experiencing.

Our ambition remains for Chorley and South Ribble Hospital to become a 'good', then 'outstanding', District General Hospital - building on its success and national reputation as a Get It Right First Time (GIRFT) accredited surgical hub. We continue to progress our plans to utilise the Cuerden modular ward space at Chorley as part of a wider overarching Trust estates strategy and expect to be in a position to provide a more specific update to our next Board meeting. At Royal Preston we will continue to focus on becoming a leading provider of specialist services alongside our DGH responsibilities and are now the lead provider for both pathology and vascular services for Lancashire and South Cumbria.

Dr Penny Dash's Review of Patient Safety

The Review of patient safety across the health and care landscape (published 7 July 2025), led by Dr Penny Dash, found that while patient safety remains a top priority in the NHS, the current landscape is overly complex and fragmented. Having six national organisations with overlapping responsibilities – Care Quality Commission (CQC), Healthwatch, Health Services Safety Investigations Body (HSSIB), the Patient Safety Commissioner, NHS Resolution, and the National Guardian's Office – creates confusion, duplication, and unclear lines of accountability. More than 70 routes for complaints and concerns were identified, with limited coordination or learning across the system.

Despite investment in safety over recent years, the report found that progress has been mixed. Improvements were noted in specific areas such as infection control and hip fracture outcomes, but serious concerns remain,

especially in maternity services, mental health, and workforce-related harm. Regional variation and persistent inequalities in patient experience and outcomes continue to undermine system-wide improvement. The report emphasises that without clearer leadership and a more unified approach, future progress will remain limited.

Dr Dash makes nine recommendations, including simplifying the landscape by integrating or reforming national bodies, clarifying responsibilities, and creating a strengthened National Quality Board to oversee strategy and accountability. Other priorities include improving data use and analytics, reforming complaints systems, enhancing board-level governance, and investing in leadership capability and safety improvement skills. She also calls for the development of a national infrastructure for quality improvement, supported by technology and patient engagement.

NHS Boards are encouraged to prepare by reviewing local governance structures, strengthening data capability, and ensuring that quality improvement, patient voice, and a strong safety culture are embedded within their organisations. The forthcoming changes will have implications for how patient feedback, safety investigations, and performance oversight are managed across the system.

Industrial action

The British Medical Association (BMA) announced national strike action by resident doctors from 7am on Friday 25 July until 7am on Wednesday 30 July 2025.

During these strikes our focus as a Trust was on ensuring as many services as possible continued to operate safely. We encouraged patients who needed urgent medical care to continue to come forward as normal, especially in emergency and serious life-threatening cases. We asked patients to attend appointments as planned if we had not contacted them regarding the need to reschedule due to strike action, which was only enacted where it was necessary.

Whilst we always respect the right of our colleagues to strike, there is inevitably a negative impact on patients and colleagues due to additional delays, uncertainty and poorer outcomes for those who have to wait longer for procedures than they would normally have done. I'd therefore like to thank all colleagues who worked during the period of the Industrial Action and also all those who contributed to all the planning needed to keep our patients as safe as possible. The BMA mandate for Industrial Action lasts for 6 months, but we very much hope to see the situation resolved before then.

Millions to benefit from NHS robot drive

NHS England report that millions of patients will benefit from cutting-edge robotic surgery over the next decade as part of radical plans to cut waiting times. Half a million operations will be supported by the trailblazing approach every year by 2035, up from 70,000 in 2023/24, according to NHS projections.

Nine in ten of all keyhole surgeries, such as the removal of certain organs affected by cancer, will be delivered with robot assistance within the next ten years, up from one in five today, with robotic surgery being the default for many operations. The NHS also expects to see increasing numbers of emergency operations using the technology – which can be more precise than the human hand.

Here at Lancashire Teaching Hospitals, we have been performing robotic surgery, specifically with the da Vinci Xi system, for a range of procedures since 2017, and recently completed the 1,000th robotic prostatectomy.

Nichola Collins, of Thornton-Cleveleys, who had a hysterectomy at Chorley and South Ribble Hospital, was a case study for the NHSE press release. Nichola was home within 24 hours, which was "significantly quicker" than she expected and described what a huge difference the surgery had made to her quality of life.

Pathology Service Update

We are moving towards a single, unified pathology service for Lancashire and South Cumbria. Lancashire Teaching Hospitals will be the lead provider with the support of colleagues across the system.

On Monday 28 July 2025, we started the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) information and consultation process for colleagues whose employment will transfer to LTH, this is expected to run until late January 2026. We are also engaging with LTH pathology colleagues during this period. Our aim is to launch the new single service on 1 February 2026.

For most colleagues, there will be no immediate changes to where or how they are working now. They will continue working in their current role, location, and team. There will be minimal impact for patients as a result of the formation of a single, unified service. In the long-term, patients will benefit from an improved diagnostic service.

We aim to begin transformation of our services in 2026, to bring quality improvement, standardisation of processes across the network, and equity of access – supporting referral to treatment pathways and improved clinical outcomes. This will help us to create more sustainable, efficient, and effective ways of working. Automation and digitisation will play a key role.

We're committed to involving colleagues throughout this journey, and any changes to working practices will be developed collaboratively alongside staff side (trade union) representatives.

Changes to the Executive team

This autumn, Dr Gerry Skailes will retire from the Trust after an exceptional 28 years of service, including the past seven years as Chief Medical Officer (CMO). Gerry is an immensely respected clinical leader, both within the organisation and across the wider health and care system.

Throughout her executive tenure, she has continued to see oncology patients, ensuring that her leadership remained grounded in patient care. Her calm pragmatism, deep institutional knowledge, and unwavering advocacy for keeping patients at the heart of decision-making have shaped the Trust's approach during both stable and challenging times. She made an invaluable contribution during the Covid-19 pandemic, steering the Trust through a myriad of changing protocols with clarity, compassion and unfailing good humour.

Gerry is the Senior Responsible Officer representing the system Chief Medical Officers at the Provider Collaborative Board and chairs numerous groups across the system including the Lancashire and South Cumbria Cancer Alliance and the North West Radiotherapy Operational Delivery Network (ODN).

On behalf of the Executive Team and the Board, I would like to express our sincere gratitude to Gerry and wish her the very best in her well-earned retirement. She will be very much missed by colleagues and patients alike.

Following a highly competitive and rigorous recruitment process, I was delighted to confirm the appointment of Steve Canty as our next Chief Medical Officer.

Many colleagues will already know Steve well; he has been with the Trust for 24 years and is currently Divisional Medical Director for the Surgical Division and a respected Consultant Orthopaedic Surgeon. He has regularly acted as CMO during periods of absence and has long been a trusted and visible medical leader within the organisation.

Steve's appointment has been warmly welcomed by the Executive Team, and I know Gerry is pleased to be handing over to a leader she trusts and values highly. Handover arrangements will be finalised in the coming weeks ahead of Gerry's retirement at the end of September.

In addition to his impressive track record, Steve is known for his professionalism, integrity, and approachable manner – qualities that will serve him, and the organisation, extremely well in the years ahead.

Trust wide successes and service developments

- **Work begins on refurbishment of Royal Preston Hospital Helipad**

The helipad at Royal Preston Hospital (RPH) is undergoing a major refurbishment to allow for significant upgrades. The existing structure has been closed to allow essential works to be carried out between Sunday 6 July and Friday 19 September 2025.

Estates Services are undertaking the project, which includes the installation of a new landing pad, heli lighting, signage, controls, barriers, fencing, a weather station, and improved drainage systems.

After 18 months of close collaboration between Mark Bishop (Estates) and the HELP Appeal charity, the Trust secured full funding of £720,000 for the helipad rebuild – representing the largest single charitable donation the Trust has ever received.

In preparation for the closure, Estates and clinical teams worked together to coordinate the helipad shutdown and ensure patient safety is maintained. A temporary off-site landing location has been arranged at Fulwood Barracks to allow continued air ambulance operations during the refurbishment.

- **Transformative improvements enhance services for local children and families**

The refurbishment of Broadoaks Child Development Centre in Leyland exemplifies our ambition to provide the right care in the right setting for children and young people with complex needs.

Following significant roof and internal refurbishment works, during some of which I visited the site and donned a hard hat to witness, the centre now offers a more welcoming and accessible environment for all who visit.

Broadoaks is a Trust-owned community facility for children and young people, which provides community and neurodevelopmental services across Chorley, South Ribble and Greater Preston, offering specialist assessment, coordination with other services and long-term support.

Thanks to Trust-based funding and the dedicated work of the Estates team – who collaborated closely with the Broadoaks team – the site has been significantly improved. In addition, further facilities have been repaired, adapted and improved, providing three separate WC and baby change facilities, which have been modernised. Read more about Broadoaks on our website.

- **Expanding patient-centred renal care**

In July, the Trust announced the appointment of Diaverum as the new provider of dialysis services at Clifton Dialysis Unit in Blackpool, as part of a long-term partnership to enhance renal care across the region.

Awarded through a competitive tender process, the seven-year contract with Diaverum reflects an ongoing commitment to securing high-quality, sustainable care for patients living with chronic kidney disease in Lancashire and South Cumbria.

Located within the grounds of Clifton Hospital – a site recognised nationally for innovation in patient-centred care – the dialysis unit currently treats 94 patients across 24 stations, supported by a team of experienced professionals. Diaverum's arrival marks the beginning of a new chapter in renal services for the Fylde Coast,

combining local continuity with the strength of a national provider network. Read more about the expansion of patient-centred renal care on our website.

- **New Cancer Academy partnership for Rosemere Cancer Education Hub**

In June, we were pleased to confirm a cancer education partnership between the Rosemere Cancer Education Hub at Lancashire Teaching Hospitals and Cheshire and Mersey Cancer Academy.

Together, we are committed to advancing cancer education and training by empowering healthcare professionals with the skills and knowledge to deliver outstanding care across our regions.

The collaboration to allow all staff across Lancashire and South Cumbria to access their comprehensive Cancer Academy resources. This approach avoids duplication and ensures access to high-quality, established cancer education programmes. Read more about the Cancer Academy partnership on our website.

- **Cutting-edge cancer treatment boost for Trust**

Our role in the national radiotherapy modernisation programme will see a new linear accelerator (LINAC) installed at Rosemere Cancer Centre, helping us meet national targets and improve time to treatment.

The Trust is one of three in the North West – alongside The Christie NHS Foundation Trust and The Clatterbridge Cancer Centre NHS Foundation Trust – to benefit from a share of a £70 million government investment to modernise cancer treatment through the Plan for Change.

The machines are due to be rolled out from August as part of government plans to improve cancer care through the Plan for Change. By March 2027, up to 27,500 additional treatments per year will be delivered nationally, including up to 4,500 receiving their first treatment for cancer within 62-days of referral, helping to treat more cancer patients more quickly. Read more on our Trust website.

- **Celebrating Silver Accreditation success**

Our Clinical Applications Training and Support Team were awarded the Silver Accreditation Standard by the Skills Development Network in June. This is not only a remarkable achievement, but also a first for Lancashire Teaching Hospitals. The Silver Accreditation recognises NHS training teams that consistently deliver high-quality, effective training across the North West.

Achieving this standard involved a rigorous, peer-assessed process, where the team demonstrated their commitment to training and skills development. They provided extensive evidence of their capabilities, underwent external assessment, and met demanding criteria with flying colours. The Silver level confirms that the team is delivering an advanced training service, excelling in how they design, deliver, and evaluate their programmes. It's a powerful reflection of their dedication to professional growth and excellence in clinical application training.

- **Celebrating 100 years with the help of our Frailty team**

Our Frailty team at Royal Preston Hospital enabled Wallace to return home in time for his 100th birthday, showcasing truly joined-up, patient-centred care. When Wallace experienced two falls in quick succession, he was brought to the Emergency Department for further assessment.

He was reviewed by a Frailty Specialist Nurse for a Comprehensive Geriatric Assessment (CGA), exploring his health, daily function and living circumstances prior to the falls, and was referred to the therapy team, who assessed his mobility and issued him with a wheeled Zimmer frame and caddy.

The team worked swiftly and safely to facilitate discharge, with a follow-up plan in place through the Virtual Frailty Ward. Wallace returned home that afternoon and was seen on the following Monday by Clare Easton, Frailty Specialist Nurse. Clare completed a clinical review, advised on medication management, liaised with his family, and provided education around hydration and overall wellbeing. Wallace's case was reviewed at the Frailty Virtual Ward multidisciplinary team (MDT) meeting with the Consultant Geriatrician.

The Virtual Ward Occupational Therapist visited Wallace at home, identified further equipment needs, and made environmental recommendations to reduce the risk of future falls – such as rearranging furniture and removing loose rugs.

Clare visited Wallace again on his 100th birthday and he expressed heartfelt thanks for the care he received, while his son praised the team for everything they had done, and delivering on what they had promised. Special thanks go to all the professionals who helped make Wallace's wish a reality, including colleagues in ED, Wendy Weaver (CNS), Akin Omotoso (OT), Holly Parkinson (TTAP), and Hayley Wellerd (OT).

- **Oluchi is a finalist in the 2025 Student Nursing Times Awards**

Oluchi Okoroafor, Senior Healthcare Assistant with the Trust and a postgraduate student (Adult Nursing) at the University of Salford, was shortlisted for two categories at the 2025 Student Nursing Times Award.

Oluchi was shortlisted in the Student Nurse of the Year: Adult category and Mary Seacole Award for Outstanding Contributions to Diversity and Inclusion. Judges said: "Oluchi is a dedicated nursing student at the University of Salford, recognised for her leadership, academic excellence, and commitment to supporting peers. Oluchi has been commended for her leadership, teamwork, and teaching skills. Passionate about cultural competency and compassionate care, Oluchi continues to inspire those around her through her dedication to nursing education and practice. The student is a confident and influential advocate for both national and international nursing students, effectively using her voice to drive positive change."

- **Dr Jha is first in the UK to achieve prestigious European certification**

As he outlined in his spotlight presentation at the internal Leaders Forum in July, Avinash Jha has become the first Intensive Care Unit Consultant in the United Kingdom to achieve the European Society of NeuroSonology and Cerebral Hemodynamics (ESNCH) certification.

Dr Jha was awarded the internationally recognised neurosonology certification in Budapest, Hungary, after passing a demanding two-part exam. This much-coveted qualification now formally recognises his ability to use ultrasound to examine the brain at the bedside, a skill previously limited mainly to neurologists.

Dr Jha said he intends to use his expertise to expand the use of bedside brain ultrasound by training, mentoring and developing services to ensure that critical care staff can learn to use brain ultrasound as a new and powerful non-invasive tool to improve neurological examination and outcome of the critically ill. Read more about Dr Jha on our website.

- **Layla is a Rising Star!**

Layla Fowler won the Hospital Caterers Association Rising Star Award 2025 in July. Interim Assistant Manager for Domestic Services working within the Facilities Management portfolio, Layla's award success reflects her commitment and dedication to deliver the first system wide Facilities Management vending tender on behalf of Lancashire Teaching Hospitals – believed to be the largest NHS supply chain contract, relating to all snacks, hot and cold drinks, and 24-hour hot food vending machines.

The vending tender involved a lengthy and challenging process, before a contract, for an initial five years with the option for an extra two, was signed with supplier North West Vending (NWV). A total of 300 products were taste-tasted, with sustainability, quality and value taken into account, as well as disability access, dietary requirements and social value. The implementation of the contract has improved out-of-hour hot food access for staff, patients, and visitors, with 24-hour vending machines installed at Preston Business Centre, Royal Preston Hospital and Chorley Hospital. Read more about Layla on our website.

- **Rachel nominated for Soldiering On Awards**

Rachel Diss, Occupational Therapist with the Trust, has been nominated for the Soldiering On Awards, in the Defence Inclusivity category for the amazing work that she does on a voluntary basis at a national level to support young people within the Army Cadet Force (ACF).

She has played a vital role over the past 15 years, transforming policies, practices and culture to bring about meaningful change that reflects the diverse communities that the ACF serves.

From launching inclusive strategies and regional forums to delivering training and developing accessible resources, Rachel's work has led to a marked rise in engagement from underrepresented groups, empowering both cadets and volunteers to lead with confidence and pride. The winners will be revealed at a spectacular black-tie ceremony in October 2025 at London's Park Plaza Westminster Bridge Hotel, where Jeremy Vine will host the awards.

- **Long service award for Memuna**

In June, following on from National Volunteers' Week at the start of the month, I was delighted to meet with a select group of our volunteers to talk about their roles around the Trust.

There was also a special commemoration as received her 30-year-long service certificate. Memuna is a volunteer on the information desk at Royal Preston Hospital. She gives patients and visitors help and assistance to find their way around the Trust. Memuna volunteers with us during school holidays as she works at a local school during term time.

- **Trust re-accredited as a Veteran Aware organisation during Armed Forces Week**

I was delighted that, during Armed Forces Week in June, the Trust was re-accredited as a Veteran Aware organisation by the Veterans Covenant Healthcare Alliance (VCHA).

This demonstrates our commitment to honouring the Armed Forces Covenant and ensures that those who have served our country receive care that recognises their unique experiences and needs.

Being Veteran Aware means we understand the specific needs of veterans and the wider armed forces community; train staff to be aware of and responsive to those needs; display the Armed Forces Covenant, making our pledge visible to patients and staff; signpost veterans and their families to relevant support services and ensure policies reflect the commitment to equitable care. You can read more about our Veteran Aware re-accreditation on our website.

- **Former Trust colleague Gregg's pride as he receives his MBE from King Charles**

The achievements of former colleagues like Gregg Stevenson – now an MBE recipient and Paralympic gold medalist – highlight the long-term value and influence of our services on recovery, inclusion, and inspiration. Gregg received his MBE from King Charles at Buckingham Palace in June.

Read more about Gregg Stevenson being awarded his MBE on our website.

- **Bishop of Lancaster celebrates historic mass at Royal Preston Hospital**

I was privileged to be present as a moment of spiritual significance and celebration took place at Royal Preston Hospital, as the Bishop of Lancaster, the Right Reverend Paul Swarbrick, celebrated mass in the chapel.

The special 50-minute service brought together senior leaders, chaplaincy staff, patients and volunteers, with the Bishop assisted by the Reverend Simon Gilbertson, chaplain at the Trust, Father John Mark Agulefo, from St Claire's Parish, and Father Francisco Ulogu from St Mary's, Fernyhalgh.

During the service, the Bishop invited chaplains to publicly reaffirm their commitment to their vocation and their dedication to providing spiritual care within the hospital setting.
Read more on our website.

RECOMMENDATIONS

i. It is recommended that the Board receive the report and note its contents for information.

8. BOARD ASSURANCE FRAMEWORK

Decision Item | S Regan | 09.50am

REFERENCES

Only PDFs are attached

8.0 - BAF Risk Paper - Aug 2025 - Final.pdf

Board of Directors Report

Board Assurance Framework (BAF) Risk Report

Report to:	Board of Directors	**Date:**	7 August 2025
Report of:	Associate Director of Risk & Assurance	**Prepared by:**	K Clay
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The Well Led Framework by NHS England and the Care Quality Commission (CQC) requires Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's objectives.

This paper provides an update on the BAF following the review and approval of the Principal Risks to the delivery of the 2025/26 Corporate Objectives.

Principal Risks

The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the Corporate Objectives. Due to scheduling of committees, the Principal Risks detailed in Appendix 1 are those that have been presented to Committees of the Board, or reviewed in preparation for the next Committee at the time of writing this paper. Updates since the last Board of Directors meeting:

- Principal Risk numbers have been refreshed for 2025/26 since the last meeting of the Board of Directors.
- Principal Risk 2 (C.*difficile* infection) – there continues to be slightly lower cases of C.*Difficile* than previously seen and the risk score will be monitored as the National Standards of Cleaning continue to be rolled out.
- Principal Risk 4 (timely access to planned and cancer care) - scoping of the administrative target operating model and digitisation options is underway with the project management office (PMO). In addition, there are ongoing contract discussions with the Integrated Care Board (ICB) to achieve the funding for the required levels of activity. It is anticipated that this risk score will be reviewed at month 6 to consider the trajectory towards the Corporate Objective aims.
- Principal Risk 7 (Reliance on temporary medical workforce) – there has been progress following the development of an assurance report provided to Safety & Quality Committee in June 2025. Challenges remain in progressing the 42 week productivity reporting. However, it is anticipated the risk score may be able to reduce in the coming months should positive assurance continue to be available in relation to vacancies, agency and locum usage, alongside improved assurance reporting at Safety & Quality Committee.
- Principal Risk 8 (Experience of staff, with specific focus on under-represented staff groups) – this has now been updated to include wider staff experience and the target control date has been moved to the end of the financial year given the wider focus and the need to measure improvement action outcomes.
- Principal Risk 12 (Failure to meet the financial plan 2024/25) - progress has been made. The majority of plans to deliver the Waste Reduction Programme have been developed, the focus is now onto delivery of the schemes. The risk score will be reviewed around month 6 to consider progress against the plan for this financial year and whether the risk to delivery of the Corporate Objective has reduced.

- Principal Risk 13 (cash consequences of the Trust's underlying financial position remains) has increased in score from 12 to 20 in recognition of the stricter approach to cash support from NHS England and in response to the profile of the waste reduction programme (WRP), which leads to an increased risk that there may be limited cash availability from August 2025 should the Trust's request for cash support not be met. Clarification on the parameters for continuing cash support is anticipated and the risk score will be reflected upon once this is received.

Operational High Risks for Escalation/De-escalation

There are currently no operational high risks of concern escalated to the Board within the BAF this month.

It is recommended that Board of Directors:

- Note and approve the updates to the BAF.

Appendix 1 – Board Assurance Framework

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Committees of the Board in line with cycles of business

1. Background

1.1 The Well Led Framework by NHS England and the Care Quality Commission (CQC) requires Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's objectives.

1.2 This paper provides the Board of Directors with an update on the BAF following the review and approval of the Principal Risks to the delivery of the 2025/26 Corporate Objectives.

2. Board Assurance Framework

2.1 The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the corporate objectives.

2.2 It should be noted due to scheduling of Committees, the Principal Risks detailed in Appendix 1 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper. Updates since the last Board of Directors meeting include:

- Principal Risk numbers have been refreshed for 2025/26 since the last meeting of the Board of Directors.
- Principal Risk 2 (C.*difficile* infection) – there continues to be slightly lower cases of C.*Difficile* than previously seen and the risk score will be monitored as the National Standards of Cleaning continue to be rolled out.
- Principal Risk 4 (timely access to planned and cancer care) - scoping of the administrative target operating model and digitisation options is underway with the project management office (PMO). In addition, there are ongoing contract discussions with the Integrated Care Board (ICB) to achieve the funding for the required levels of activity. It is anticipated that this risk score will be reviewed at month 6 to consider the trajectory towards the Corporate Objective aims.
- Principal Risk 7 (Reliance on temporary medical workforce) – there has been progress following the development of an assurance report provided to Safety & Quality Committee in June 2025. Challenges remain in progressing the 42 week productivity reporting. However, it is anticipated the risk score may be able to reduce in the coming months should positive assurance continue to be available in relation to vacancies, agency and locum usage, alongside improved assurance reporting at Safety & Quality Committee.
- Principal Risk 8 (Experience of staff, with specific focus on under-represented staff groups) – this has now been updated to include wider staff experience and the target control date has been moved to the end of the financial year given the wider focus and the need to measure improvement action outcomes.
- Principal Risk 12 (Failure to meet the financial plan 2024/25) - progress has been made in identifying waste reduction programme schemes, the focus has now shifted to delivery. The risk score will be reviewed around month 6 to consider progress against the plan for this financial year and whether the risk to delivery of the Corporate Objective has reduced.
- Principal Risk 13 (cash consequences of the Trust's underlying financial position remains) has increased in score from 12 to 20 in recognition of the stricter approach to cash support from NHS England and in response to the profile of our current waste reduction programme (WRP), which leads to an increased risk that there may be limited cash availability from August 2025, should the Trust's request for cash support not be met. Clarification on the parameters for continuing cash support is anticipated and the risk score will be reflected upon once this is received.

3. Operational High Risks for Escalation/De-escalation

3.1 There are currently no operational high risks escalated to the Board within the BAF this month.

4. Financial implications

4.1 Any financial implications are captured within the Risk Register records and managed accordingly.

5. Legal implications

5.1 Any legal implications are captured within the Risk Register records and managed accordingly.

6. Risks

6.1 The paper identifies Principal and Operational Risks that may compromise the achievement of the Trust's high level Strategic Objectives and therefore, the entirety of the paper is risk focused.

7. Impact on stakeholders

7.1 A robust and well managed BAF reduces the negative impact on patients and staff and the reputation of the organisation. Its purpose is to mitigate and reduce, as far as is reasonably practicable, the level of risk to that identified in the Trust risk appetite statement.

7.2 All risks can impact upon patient experience, staff experience, the Integrated Care System and cross divisional work. This is captured within individual risk register entries on Datix.

8. Recommendations

8.1 It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.

Lancashire Teaching Hospitals
NHS Foundation Trust

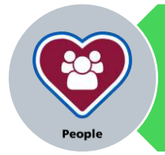
Board Assurance Framework

2025/26

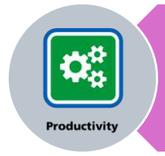
Board of Directors – August 2025

Patients – deliver excellent care

Performance – deliver timely, effective care



People – be a great place to work



Productivity – delivery value for money

Partnership – be fit for the future

Excellent care with compassion

Always Safety First

@LancsHospitals

How the Board Assurance Framework fits in

Strategy: Our strategy sets out our ambitious plans between 2025 – 2030 to enhance healthcare delivery, align with the NHS Long Term Plan, and continue our journey towards building a new hospital that meets the evolving needs of our communities that we serve both locally and across Lancashire and South Cumbria. Our new strategic framework is founded on our vision and values and organised around five strategic objectives – our '5 P's': Patients, Performance, People, Productivity and Partnership.

Corporate objectives: Each year the Board of Directors agrees corporate objectives which set out in more detail what we plan to achieve over a 12-month period. The corporate objectives are designed to focus on delivery of the priorities during the year, which will support the overall delivery of the objectives identified within the strategy.

Board Assurance Framework: The Board Assurance Framework (BAF) provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains principal risks which are the risks considered most likely to materialise and those which are likely to have the greatest adverse impact on delivery of the corporate objectives, and therefore could also affect the ability to deliver the overall objectives set out in the strategy.

Seeking assurance: To have effective oversight of the delivery of our corporate objectives, the Board of Directors uses its committee structures to seek assurance on its behalf. Whilst individual corporate objectives will cross a number of our strategic objectives, each is allocated to one specific strategic objective for the purposes of monitoring. Each principal risk is allocated to a monitoring committee who will seek assurance on behalf of, and report back to, the Board of Directors.

Accountability: Each principal risk has an allocated Director who is responsible for leading on delivery. In practice, many of the principal risks will require input from across the Executive Team and from senior leaders as part of the Trust's accountability framework. However, the lead Director is responsible for monitoring and updating the principal risks that make up the Board Assurance Framework, and has overall responsibility for the areas for improvement. Some principal risks may require external actions / improvements and where this is the case, the lead Director will be responsible for leading on behalf of the Trust and developing actions in consultation with external stakeholders.

Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance. It is recognised that elements of this document may not support accessibility standards, but this can be re-produced in an accessible form if required. Should this be required, please contact company.secretary@lthtr.nhs.uk.

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

Likelihood →						
	5 Almost Certain	5 Moderate	10 Significant	15 High	20 High	25 High
	4 Likely	4 Moderate	8 Significant	12 Significant	16 High	20 High
	3 Possible	3 Low	6 Moderate	9 Significant	12 Significant	15 High
	2 Unlikely	2 Low	4 Moderate	6 Moderate	8 Significant	10 Significant
	1 Rare	1 Low	2 Low	3 Low	4 Moderate	5 Moderate
		1 Neglible	2 Minor	3 Moderate	4 Major	5 Catastrophic
		Consequence →				

DIRECTOR LEADS	
CEO	Chief Executive Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CNO	Chief Nursing Officer
CPO	Chief People Officer
CMO	Chief Medical Officer
DCE	Director of Communications & Engagement
CSIO	Chief Strategy and Improvement Officer
CIO	Chief Information Officer

Definitions	
5 P's	The 5 P's is an abbreviation to describe the five strategic objectives – Patients, Performance, People, Productivity and Partnership
Corporate Objectives	The corporate objectives are designed to focus on delivery of the priorities during the year, which will support the overall delivery of the strategic objectives.
Principal risks	Risks to the delivery of the corporate objectives, which are considered most likely to materialise and those which are likely to have the greatest adverse impact on delivery. There is also therefore the potential to affect the ability to deliver the overall strategic objectives. Principal risks populate the Board Assurance Framework. Potential risks to delivery are monitored through the Single Improvement Plan and the Integrated Performance Report. Principal Risks are approved by the Board and managed through Lead Committees and Directors.
Controls	The measures in place to reduce the likelihood and/or the consequence of the risk to secure a reasonable level of control.
Gaps in Controls	Areas which require action/attention to ensure that appropriate controls are in place to secure a reasonable level of control.
Assurances	A measure/methodology/source which provides confirmation that the control measures put in place are effective and sustainable to secure a reasonable level of control. These can be internal or external sources, depending on the risk and the appropriate level of assurance required.
Gaps in Assurances	Areas where there is limited or no assurance that the control measures put in place are effective and sustainable to secure a reasonable level of control.
Risk Treatment:	Actions required to mitigate the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.

Our strategic approach at a glance

Our vision
- Working together to improve the health and wealth of the population we serve

Our purpose
- To provide the best specialist and local health and care services

Our values
- Caring & Compassionate
- Building Team Spirit
- Seeking to Involve
- Recognising Individuality
- Taking Personal Responsibility

Strategic priorities
- Advanced Diagnostics
- Anchor Institution
- New Models of Care & Population Health
- Pioneering Specialist Services
- Stronger links with Academic Partners

Lancashire & South Cumbria New Hospitals Programme

Strategic framework
- **The 5 Ps**
- **P**atients
- **P**eople
- **P**artnership
- **P**roductivity
- **P**erformance

Enabling strategies
Always Safety First • Digital • Estates & Facilities • Finance • Workforce

Single Improvement Plan

Partnerships | People | Patients | Productivity | Performance

Strategic Objectives

Patients – deliver excellent care
Improve outcomes, reduce harm and deliver a positive patient experience

Performance – deliver timely, effective care
Deliver agreed trajectories in clinical performance

People – be a great place to work
Create an inclusive culture with leaders at every level leading colleague engagement

Productivity – deliver value for money
Deliver the agreed financial plan including waste reduction programme, maximising use of resources

Partnership – be fit for the future
Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions

2025/26 Corporate Objectives

Patients
- Improve outcomes and prevent harm
- Deliver a positive patient experience
- Develop new ways of working across the system that lead to more effective patient interventions and pathways.
- To deliver good tertiary services to the population of Lancashire and South Cumbria and District General Hospital Services to the population of Central Lancashire

Performance
- To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan
- To minimise the risk of harm to patients through the delivery of our elective recovery plan
- To improve the responsiveness of urgent and emergency care
- To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory

People
- To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy
- To strive to improve experience at work by actively listening to our people, and turning understanding into positive action
- To be consciously inclusive in everything we do.
- To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.
- To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.

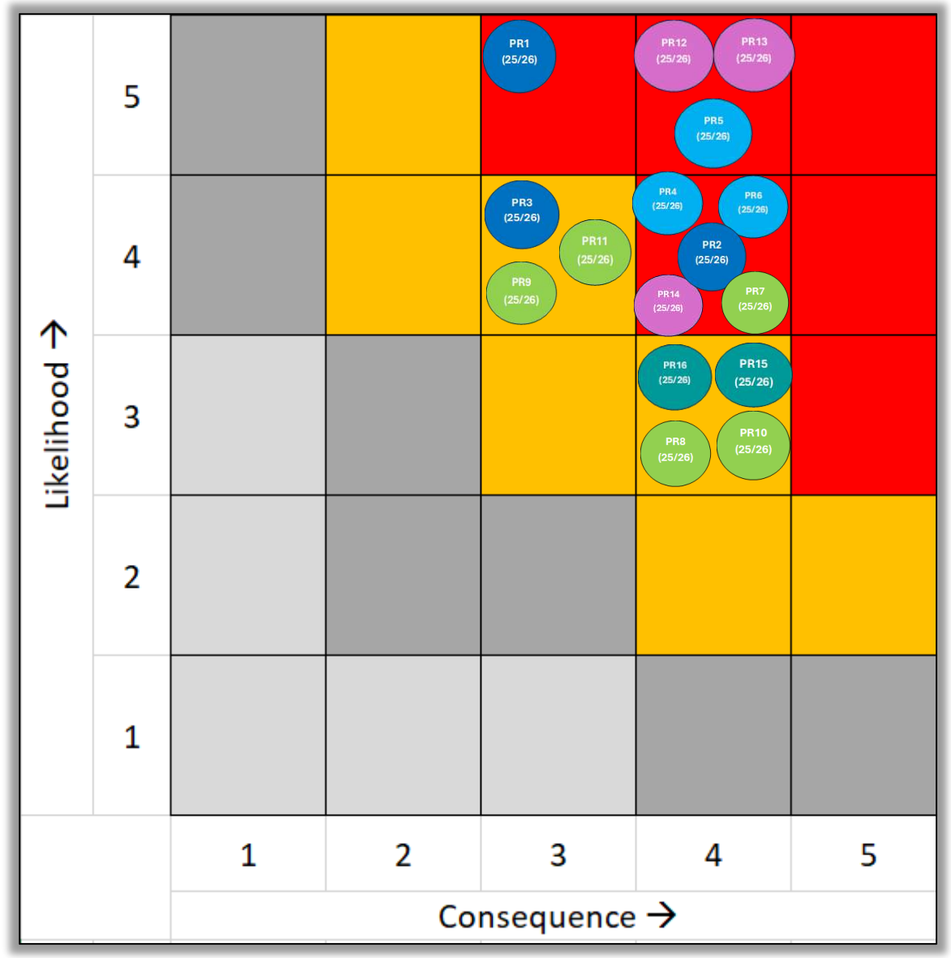
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency
- To develop a clinical services strategy for the organisation

Partnership
- To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.
- Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.
- To make progress towards our ambition to be a University Teaching Hospital
- Working with partners, create a single pathology service

Principal Risk Management

Our Risk Appetite and Tolerance position is summarised in the table and the heat map shows the distribution of the principal risks based on the current score.

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (25/26)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15	→
PR2 (25/26)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6	16	→
PR3 (25/26)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12	→
PR4 (25/26)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16	→
PR5 (25/26)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20	→
PR6 (25/26)	Timely access to diagnostic investigations	COO	Performance	FPC	Cautious	1-6	16	→
PR7 (25/26)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8	16	→
PR8 (25/26)	Experience of staff, with specific focus on under-represented staff groups	CPO	People	WFC	Open	4-8	12	→
PR9 (25/26)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8	12	→
PR10 (25/26)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12	→
PR11 (25/26)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8	12	→
PR12 (25/26)	Failure to meet the financial plan 2025/26	CFO	Productivity	FPC	Cautious	8-12	20	→
PR13 (25/26)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Cautious	8-12	20	↑
PR14 (25/26)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Cautious	8-12	16	→
PR15 (25/26)	Research capacity and capability to enable progress towards University Hospital status	CSIO & CMO	Partnership	ETR	Seek	8-12	12	→
PR16 (25/26)	Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC	CSIO& CMO	Partnership	FPC	Seek	8-12	12	→



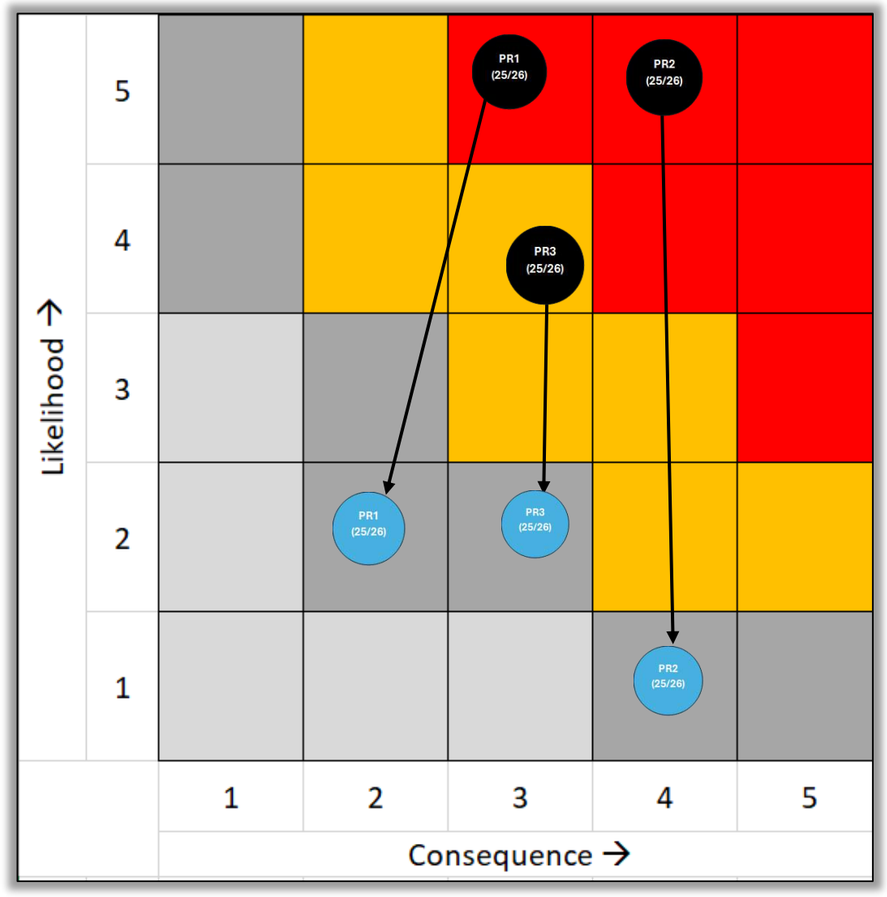
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

The following 2025/26 corporate objectives are aligned to the **Patients** strategic objective:

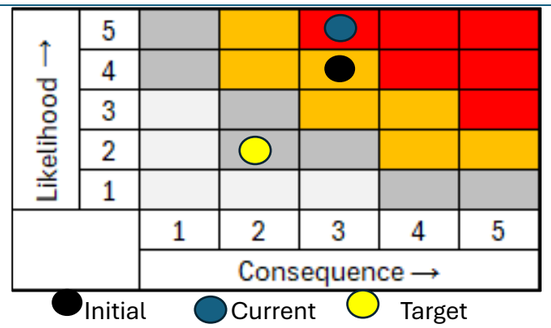
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Design a new medical model for UEC pathways. • Improvement to meet the average time to see a clinician in ED standard • Internal professional standards will be met by each specialty • Develop approach to medical staffing assurance. • Deliver medicines safety and optimisation programme • Lead delivery of CQC action plan • Continued implementation of PSIRF & demonstrate maturity in the approach to learning. • Implement the Always Safety First and learning strategy 2025-2028 • Deliver agreed C.difficile improvement actions • Deliver 10 CNST maternity neonatal safety actions • Deliver annual safe staffing requirements • Deliver the Health Improvement Plan: Our plan to reduce health inequalities	Risk identified
CO2	Deliver a positive patient experience	• Improve the experience of inpatients, improve position in ED and children and maintain positive position in cancer and maternity surveys • Implements a change in culture in UEC pathways focussing on preventing deconditioning and reducing 'days kept away from home' and in elective services ' days worrying'.	Risk identified
CO3	To develop new ways of working across the system that lead to more effective patient interventions and pathways.	To deliver more services to patients outside of hospital: • Lead the approach to community transformation • Develop & deliver the community transformation plan • Establish new ways of working with primary care to promote partnership approach to transformation • Clinically lead the transformation of patient pathways	Risk identified
CO4	To deliver good tertiary services to the population of Lancashire and South Cumbria and District General Hospital Services to the population of Central Lancashire	• Progress the Integrated Care Board and Provider Collaborative Board clinical services programme for vascular, urology, haematology and head and neck. • Progress in tertiary services peer review compliance. • Develop an approach to frailty and end of life care that meets the needs of the local population.	Risk identified



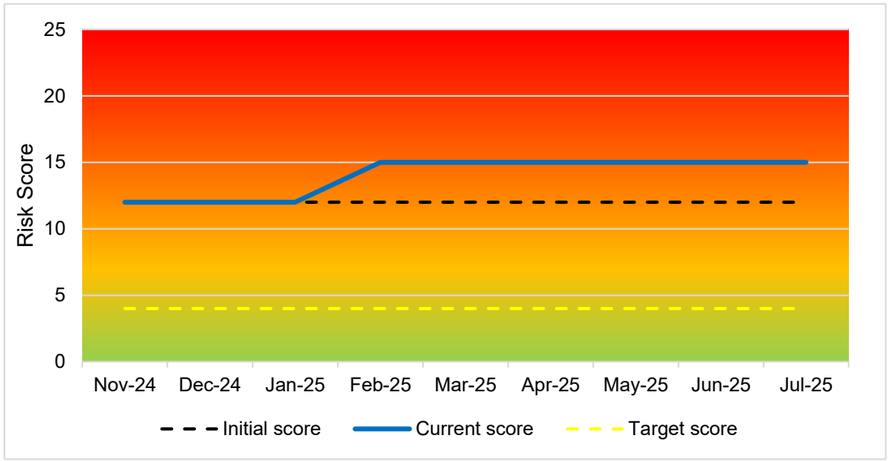
Heat map key: Black = current score, Blue = target score

Strategic Objective: Patients	**Corporate Objective:** Deliver a positive patient experience	Overall Assurance Level	Medium

Principal risk 1 (25/26) (ID 2102)	Risk Title:	Patient experience within the urgent and emergency care pathway		
	Risk Description:	There is a risk that patient experience within the urgent and emergency care pathway may be negatively impacted due to high service demand, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	18/07/25	
		Target control date	31/08/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

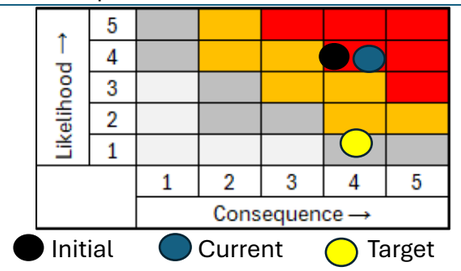
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Urgent & Emergency Care Delivery Board. • Urgent & Emergency Care Picker Survey Action Plan. • Discharge Improvement Plan.	• Community demand for primary and UEC services. • Alternatives to Emergency Care. • Ageing estate and environment. • Sub-optimal escalation areas. • Being cared for in areas that are waiting areas / not traditional bed spaces. • Financial constraints. • Unpredictability of patient acuity. • Gap in the required number of beds. • Patients cared for outside of designated bed spaces.	<u>Level 1 Assurance</u> • Complaints and concerns – approx. less than 1% versus attendances. • ED dashboard provides monthly overview of safety, quality and performance metrics in ED. • Improved position at CDH in relation to time to triage, average time to see a clinician. • STAR patient experience has some areas of positive performance. <u>Level 2 Assurance</u> • Patient Experience & Involvement Group reports to Safety & Quality Committee • Urgent and Emergency Care Picker Survey reported to Safety & Quality Committee. <u>Level 3 Assurance</u> • Friends & Family Test – some areas of positive assurance.	• Time to see a clinician at RPH consistently exceeds the 60 min average target. • Urgent and Emergency Care Picker Survey identified areas for improvement. • Friends and Family Test – gaps related to communication, waiting times and overall experience.

Risk Treatment

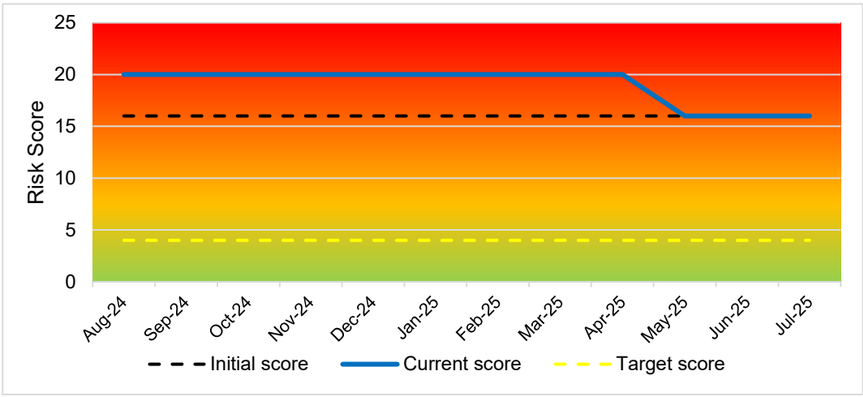
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Development of patient experience improvement plan for the Single Improvement Plan.	S. Morrison	30.06.25	30.06.25	Jul 2025: New action identified. Focus on inpatient and UEC patient experience actions receiving scrutiny through the Single Improvement Plan.
Review of the approach to continuous flow and Boarding to be considered by Safety and Quality committee.	S. Morrison	30.06.25	30.06.25	Jul 2025: Report presented in line with plan.
Delivery of Urgent & Emergency Care Picker Survey Action Plan	A. Booth	31.08.25		Mar 2025: Refreshed approach to patient experience in ED underway. Recognising over occupied levels within the department are presenting limitations in how patients experience extended waits. Patient experience plan in development for 2025/26.
Implement approach to days kept away from home to reduce length of stay that leads to prolonged waits in the ED.	K. Foster Greenwood	30.09.25		Jun 2025: New action identified. Chief Operating Officer commence communications campaign, including communications to all ward/department leaders, Clinical Directors and in Trust wide communications.
Increase capacity in care connexions	S. Morrison	31.10.25		Jun 2025: New action identified. Recognise the route to improving patient experience is linked to the occupancy and waiting times within the department.

Strategic Objective: Patients	**Corporate Objective:** Improve outcomes and prevent harm	Overall Assurance Level	Medium

Principal risk 2 (25/26) (ID 1157)	Risk Title:	Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection		
	Risk Description:	There is a risk that there will be higher than trajectory rates of patients contracting C.*difficile* infection. The reasons for this are multifactorial and present a risk of increased mortality and morbidity, longer length of stay, poor patient experience, regulatory action, and reputational impact.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	09/06/21	Date of last review	11/07/25	
		Target control date	31/03/26	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

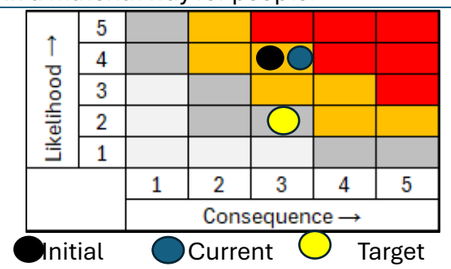
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • IPC Policy in place. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in post to drive improvements in antimicrobial usage and stewardship. • National cleaning standards in place on 15 wards, with remaining wards completing IPC audits and ward daily cleaning check lists. • Enhanced cleaning/fogging in place as required. • Sporicidal cleaning product (capable of killing C. difficile spores) is in place for general ward environmental cleaning • Ward whiteboard provides visibility of patients who present an infection risk to prompt timely action. • Isolation Room Dashboard ensures visibility of infection status in single rooms, ensuring rooms are used correctly and efficiently. • A rapid gastrointestinal test is available for exclusion of infection in diarrhoeal patients to aid rapid diagnosis. • Operational IPC meetings across Divisions. • Weekly virtual C.*difficile* ward round to support review and prevention, predominantly with relapses.	• Patient non-concordance with medical advice. • High prevalence nationally and community onset cases identified upon attendance at the hospital which creates an increased risk to others. • Non-adherence to antimicrobial guidelines in some cases. • Some staff demonstrate non-compliance with IPC advice and policy. • Isolation facilities insufficient to meet IPC needs across all infections, exacerbated by operational pressures in ED. • Ageing estate impacting upon IPC controls. • Lack of funding to support improvements to ageing estate. • A high number of blockages in the single stack sewage system leading to backflow of infectious waste into clinical areas. • A high frequency of macerator blockages and down-time leading to higher risk disposal methods of infectious waste • Lack of decant facilities to allow for thorough environmental decontamination. • Insufficient space for appropriate separation and storage of clean and dirty items on clinical areas • Funding for the implementation of the domestic services elements of the National Cleaning Standards 2021 is in place but being released in phases. There are 15 areas where this is implemented. • Delays in recruiting to domestic services vacancies due to vacancy controls in place.	<u>Level 1 Assurance</u> • IPC Dashboard triangulating process measures with outcome data. • Fogging compliance data available • Hospital acquired infection are reported on Datix. Themes and trends are monitored to identify learning. • Incident oversight in PSIRF triage meetings and regular MDT reviews under PSIRF for high prevalence wards. • For 2024/25, the final number of cases was below the trajectory by seven cases. • IPC BAF report reviewed and shared at IPCC for assurance. • IPC monthly revalidation audits including hand hygiene, commodes, environmental checks and mattress checks. <u>Level 2 Assurance</u> • Monthly reporting into S&Q Committee, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. <u>Level 3 Assurance</u> • Monthly IPC committee includes internal stakeholders and system partners from the ICB, UKHSA and LCC. • ICB & NHSE IPC Collaborative meetings. • NHS England / UKHSA external review in 2024.	• Inconsistent audits on National Cleaning Standards – 15 wards compliant. • Trust / NHS England – UKHSA Review of wards that do not have national cleaning standards in place show that this gap could be contributing to an increase in infection rates.

Risk Treatment

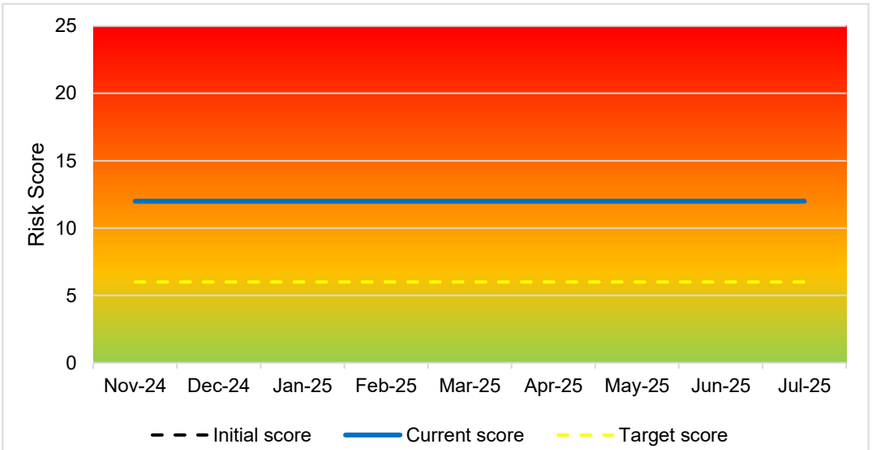
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Implement the national cleaning standards phase 2 of 3.	C. Gregory/ J. Ashley	31.10.25		Phased implementation agreed for a further 50% implementation by October 2025. Jul 25: Number of areas has now increased from 15 to 20 as part of the implementation plan.
Continue to implement the C.difficile improvement plan monitoring effectiveness through infection prevention and control committee	C. Gregory	31.03.26		Jul 2025: Annual objective for 2025/26 from the ICB. This equates to 167. Focus continues on cleaning standard implementation, including training and assurance processes. Increase assurance reporting implementing with divisions focused on areas that contribute to C.difficile prevention. Review of the NHS England IPC BAF and areas that require strengthening contained with the annual IPC report and scrutinised by Safety and Quality Committee. Will continue to review and monitor this throughout the year.
Implement the national cleaning standards phase 3 of 3.	C. Gregory/ J. Ashley	31.03.26		Full implementation planned by 31.3.26.

Strategic Objective: Patients	**Corporate Objective:** Develop new ways of working across the system that lead to more effective patient interventions and pathways	Overall Assurance Level	Medium

Principal risk 3 (25/26) (ID 2103)	Risk Title:	People experiencing Health inequalities	
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	18/07/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. • Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. • Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).	• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established.	<u>Level 1 Assurance</u> [None detailed] <u>Level 2 Assurance</u> • Monthly chairs reporting to Safety & Quality Committee • Bi-annual update on Health inequalities to Safety & Quality Committee. <u>Level 3 Assurance</u> • Annual compliance NHS statement on information on Health Inequalities – data does not suggest there are barriers for patients from areas of lower deprivation to accessing elective care services. • Quarterly Report to ICB on Health Inequalities.	• Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient's ethnicity either unknown or not stated for Central Lancashire. • Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability.

Risk Treatment

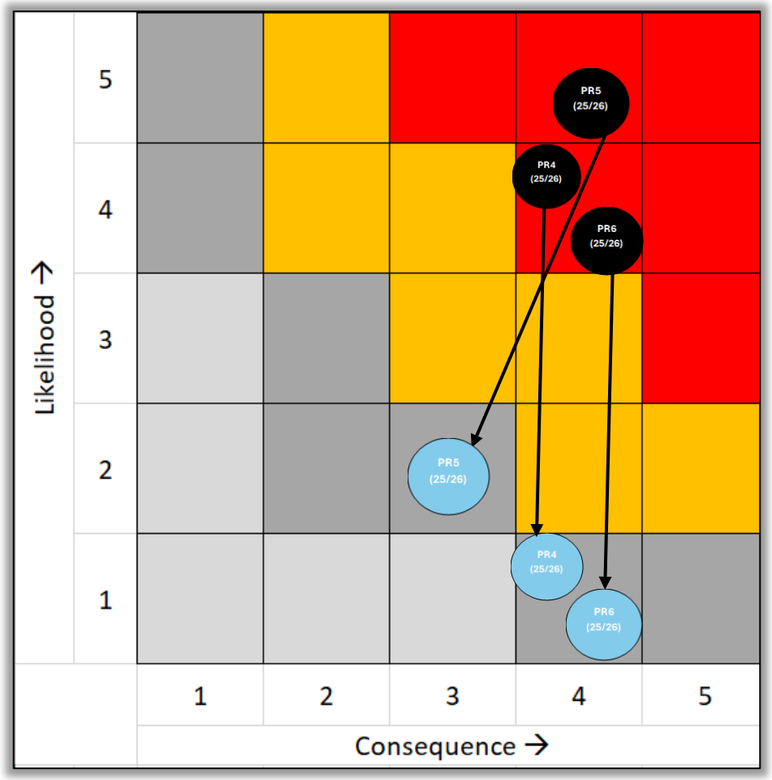
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Identify approach to driving health inequalities reduction through each portfolio of the single improvement plan	S. Morrison	~~30.06.25~~ 31.08.25		Jul 2025 – Delivery date extended from 30.6.25 to align to scheduled report to the safety and quality committee on progress relating to the health improvement plan.
Finalise Anchor Institute Plan	N. Pease	30.09.25		Jun 2025: The Social Value Strategy has been drafted and needs to be consulted upon with key contributors prior to being presented at Trust Management Board. The draft Strategy is due to be presented at Workforce Committee in July 2025 in draft form for oversight. The final version will need to be updated following receipt of feedback from various group before being finalised. Due date extended to accommodate the ongoing work.
Support case to approve the data sharing agreements between primary and secondary care.	S. Dobson	31.12.25		Jun 2025: Chief Medical Officer ICS meeting held, support required outlined and proposal now being progressed within ICS. Deadline extended to reflect resource and permissions required.
Delivery of the Trust's Health Improvement Plan through the three main strategic drivers 1. Awareness 2. Culture 3. Prevention	S. Morrison	31.03.26		Mar 2025: Plan on a page approved through health inequalities group to enable communications plan to commence. The Safety and Quality committee will receive a twice yearly update on progress against the agreed actions within the health improvement plan evidencing the Trusts contribution towards this.

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

The following 2025/26 corporate objectives are aligned to the **Performance** strategic objective:

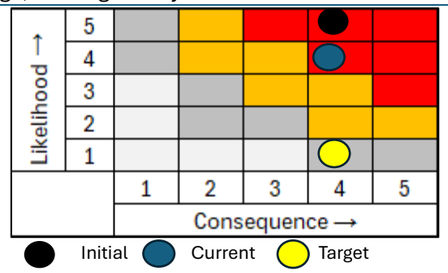
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO5	To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan	• Delivery of more elective care to further improve performance against cancer waiting times standards. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage demand effectively. • Deliver specialty and divisional improvement trajectory.	Risk identified
CO6	To minimise the risk of harm to patients through the delivery of our elective recovery plan	• Delivery of more elective care to improve performance against elective waiting times standards. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage demand effectively. • Deliver specialty and divisional improvement trajectory.	Risk identified
CO7	To improve the responsiveness of urgent and emergency care	• Working with partners, we will continue reforms to urgent and emergency care to deliver safe, high-quality care. • Specific focus on preventing inappropriate attendance at Eds. • The ED and assessment units will be designed to deliver timely assessment, treatment and discharge. • Same Day Emergency Care and virtual wards will increase in use.	Risk identified
CO8	To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory	• Delivery of the plan to improve diagnostic performance. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage access to diagnostics and improvement collaboratively, learning from Cheshire and Merseyside. • Deliver specialty and divisional improvement trajectory.	Risk identified



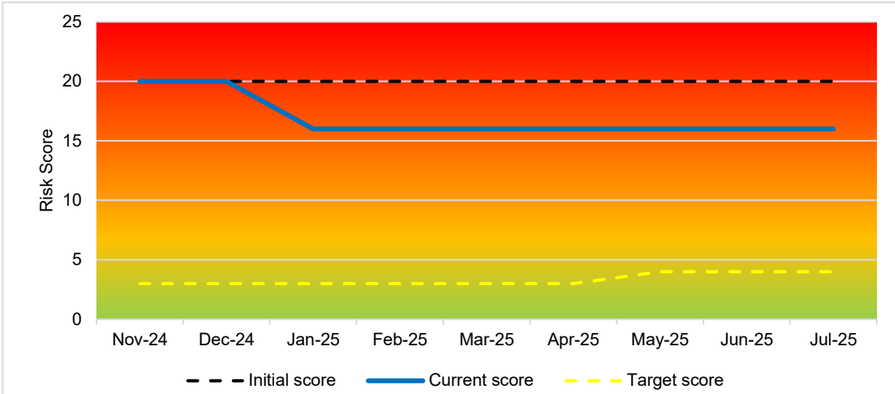
Heat map key: Black = current score, Blue = target score

Strategic Objective: Performance	**Corporate Objective:** Minimise the risk of harm to patients through the delivery of our cancer/elective recovery plan	Overall Assurance Level	Medium

Principal risk 4 (25/26) (ID 1125)	Risk Title:	Timely access to planned and cancer care	
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to planned and cancer care. This is because of backlogs that continue to be seen from the COVID period, surges in demand, shortfalls in capacity, the impact of industrial action, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely access to planned and cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	19/05/21	Date of last review	11/07/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• 25/26 Annual activity & Performance plans have been outlined to seek to deliver reduction in long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. • PEP+ (Patient Engagement Portal) and AI functionality to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. • Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. • Weekly Performance Recovery Group established to track performance and delivery of actions linked to improvement trajectories. • A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Forecasting of potential breaches for Divisions to proactively focus on patients for review and listing, focusing on month-end 52 week+ risks as part of the performance recovery group. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements.	• Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes • Inability to fully validate waiting lists regularly due to digital and workforce shortfalls. • Lack of standardised SOPs for validation. • Shortfalls in funding to support the required capacity to deliver the elective restoration plan (ERF cap). • National pension rules for clinicians means there is limited appetite for working additional hours. • Restricted admin capacity to backfill short notice procedure cancellations. • Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays • Lack of community capacity with the closure of Community Healthcare Hub and reduced capacity at Longridge resulting in high bed occupancy and increasing the risk of capacity related elective and cancer cancellations	<u>Level 1 Assurance</u> • Live PTL performance report and Validation reports. • Harm reviews process in place for >65 week and cancer pathway patients. <u>Level 2 Assurance</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DMO1 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Delays in concluding some harm reviews. • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Inability to assess the risk for patients on surveillance pathways. • Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting.

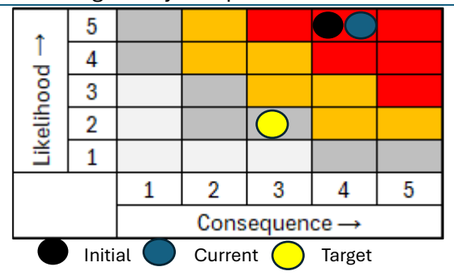
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Strengthen the data quality of opera reporting.	D. Hudson	01.07.25	01.07.25	Jul 25 - Part of the DQ assurance work identified that when generating a pended visit via Opera, the visit was being generated on the incorrect site, necessitating a transfer from one site to the other post admission. Roll out of the long term fix has been completed by Harris Flex.
Scoping & mobilisation of 6-4-2 process for Outpatients	K Foster-Greenwood	31.07.25	13.06.25	Jun 25: Pilot Control Room has been established to test a 6-4-2 principle for Outpatient productivity for an increasing number of specialities. Positive progress re improving data quality and utilisation of specialties utilising the control room methodology. Further specialties to be onboarded through the coming weeks/months.
Review of validation processes across L&SC to agree standardisation	L. Walsh	~~31.07.25~~ 30.09.25		Jul 25: Validation policies have been reviewed across all L&SC providers and the L&SC Deputy COOs are working together to draft a standardised policy. Target completion extended to September 2025.
Review of booking, scheduling and administrative resource benchmarking options	K. Foster-Greenwood	31.03.26		Jul 25: The Project Management Office (PMO) team have commenced scoping of the administrative target operating model and digitisation options. There is also an ongoing review of the admin capacity vacancy factor for Administrative & Clerical reduction to 10%.

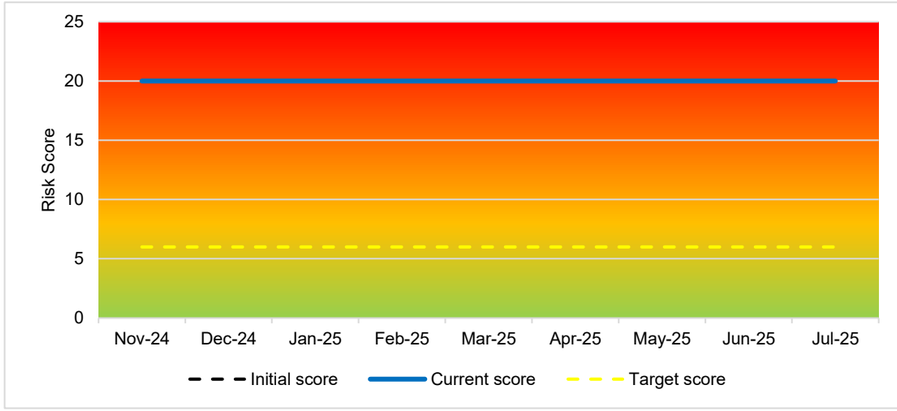
Strategic Objective: Performance	**Corporate Objective:** Improve the responsiveness of urgent and emergency care	Overall Assurance Level	Low

Principal risk 5 (25/26) (ID 2104)	Risk Title:	Timely access to urgent and emergency care
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.

Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	11/07/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

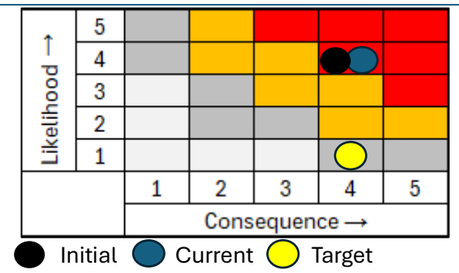
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established.	• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The environment and estate is sub-optimal.	<u>Level 1 Assurance</u> • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm. <u>Level 2 Assurance</u> • Urgent & Emergency Care and Community Transformation Board provides monthly monitoring of all improvement actions across the system. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. <u>Level 3 Assurance</u> [None detailed]	• High bed occupancy levels (above 92%). • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12 hour total wait time in the department, are not meeting the Trust targets. • Ambulance turnaround times are not meeting the Trust targets.

Risk Treatment

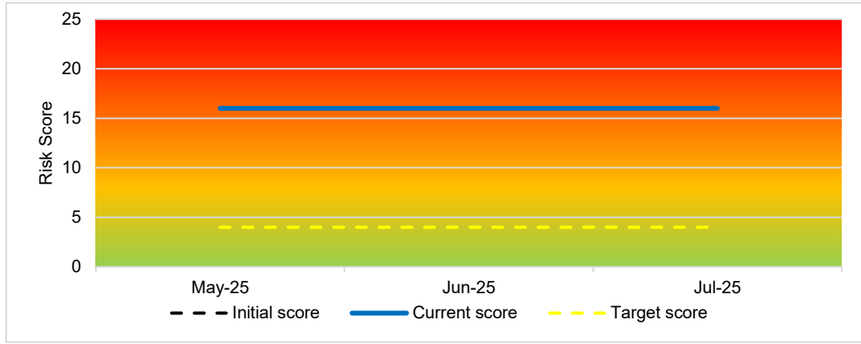
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
External support to ensure acute medical model is in line with best practice.	S. Morrison	30.06.25	16.06.25	Jun 2025: External review concluded with feedback session planned for 16th June 2025
Review and analyse 24/25 winter plan effectiveness in preparation for 25/26 plan development	K Foster-Greenwood	30.06.25	30.06.25	Jul 25: 24/25 winter plan review has been completed. Final comments requested from key clinical stakeholders ahead of presentation at Finance & Performance Committee in July 2025.
Completion of planned expansion of the surgical assessment unit (SAU).	K. Foster-Greenwood	31.07.25	16.06.25	Jun 2025: SAU opened on 16th June 2025.
Support the mobilisation of the NWAS "45 minute release to rescue" protocol	K. Foster-Greenwood	01.08.25		Jul 25: 2x trials completed and further action identified to strengthen the support. Development of site action cards to support the ED & Site management team. Continue to work with NWAS to refine the process
Implement a triage process with LCC to reduce delays and support timely decision making	L. Walsh	30.08.25		New action identified - Development of a joint triage pathway which allows for timely decision making around discharge support to reduce delayed discharge and Length of Stay
Surge planning to be concluded re Winter period 25/26	K. Foster-Greenwood	01.09.25		Jul 25: Surge planning for 25/26 has commenced. Draft plans re scheme for consideration are to be shared with Executive Management Team and Senior Leadership Team in August 2025 and finalised position to be in place by the end of August 2025.
Conclude and evaluate Ward & Board round standardisation	R Sansbury	31.03.26		Apr 25: New action identified
Development of virtual ward step up model	L. Walsh	01.09.25		New action identified - Working with LSCFT to progress the virtual ward to include step-up provision from the community to avoid hospital admission. The Virtual Ward team will co-locate with the LSCFT Virtual Ward and 2UCR team and develop pathways for step-up
Consider expanding the "Days Kept Away From Home Programme"	K. Foster-Greenwood	30.09.25		Jul 25: New action identified. Scoping of additional ward and expansion of continuous flow through AMU, Virtual Ward step-up model and review of the LCC tracker.

Strategic Objective: Performance	**Corporate Objective:** To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory	Overall Assurance Level	Medium

Principal risk 6 (25/26) (ID 2188)	Risk Title:	Timely access to diagnostic investigations		
	Risk Description:	There is a risk of delays in the completion of diagnostic investigations linked to cancer and elective pathways of care due to high levels of demand, shortfalls in capacity, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely diagnosis, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Operating Officer	5Ts status	Treat	
Date risk opened	03/06/25	Date of last review	11/07/25	
		Target Control date	31/03/26	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Diagnostic Improvement Group has been established to monitor progress of all improvement trajectories, support demand management, the use of technology and monitor productivity. • All Diagnostic modalities have undertaken a capacity and demand analysis and set improvement trajectories. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority using 'D codes' to support scheduling the most clinically urgent. • Diagnostic waiting validation processes are in place to ensure all capacity is effectively used. • Additional capacity has been commissioned for M1-6 25/26. • Weekly monitoring of cancer PTLs to reduce any delays is in place supported by a day zero PTL approach with tumour specific action plans in place. ICB support and performance monitoring re Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. • Weekly Chief Operating Officer monitoring forum for core diagnostic modalities. • Weekly Performance Recovery Group established to monitor performance.	• Lack of capacity to deliver comprehensive diagnostic waiting list validation. • Funding to support additional capacity ceases in M6 25/26. • Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes. • Physical estate and capital equipment constraints limit available capacity. • Limited influence re external (primary care) demand management.	<u>Level 1 Assurance</u> • Live PTL performance report. • Validation reports. • Datix incident reporting of any treatment delay related harms – review via SI/PSIRF processes with shared learning reports. • Benchmarking data – model hospital, GIRFT, etc <u>Level 2 Assurance.</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DM01 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Data sets lack inequalities data visibility to assess the risk of poorer outcomes between patient groups on PTLs • Datix incident reporting to assess harms of treatment delays is retrospective

Risk Treatment

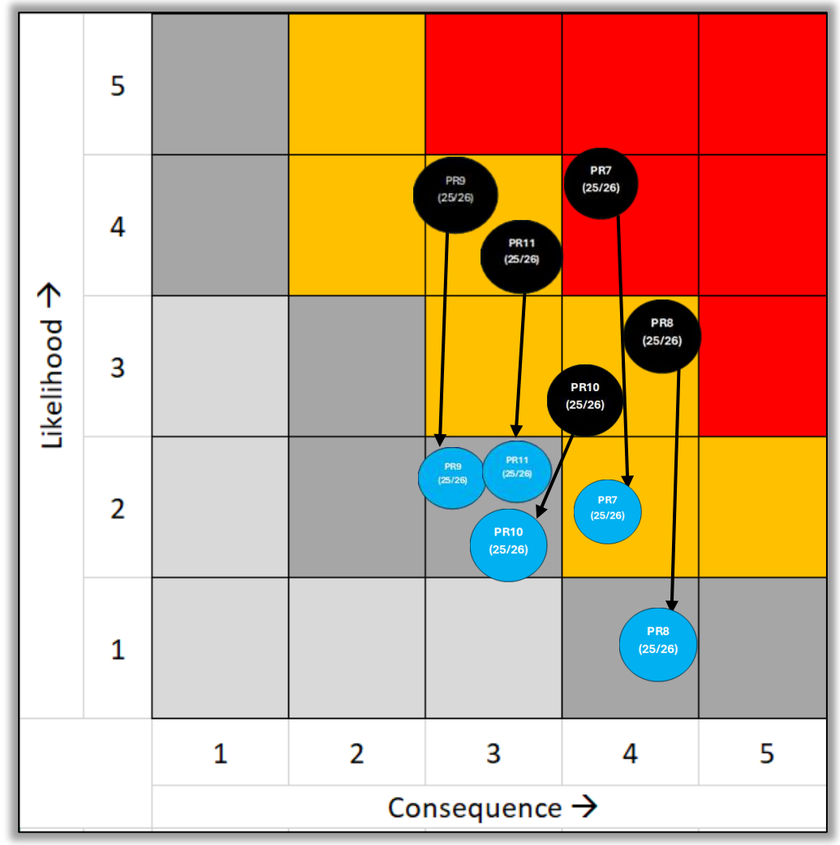
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Establish a Demand Management forum with L&SC ICB	K. Foster-Greenwood	30.06.25	07.07.25	Jul 25: Initial L&SC Demand Management meeting held on 7th July 2025. Inaugural meeting being mobilised.
Review options to increase capacity via skill mix changes for Urological diagnostic tests	K. Foster-Greenwood	31.07.25		Jul 25: Options paper is to be presented to the Surgical Divisional Board in July 2025 and once ratified will be escalated for wider approval.
Review internal demand utilisation benchmarking data and agree actions	K. Foster-Greenwood	~~30.06.25~~ 29.08.25		Jul 25: Further analysis required by clinical teams following concerns with initial data findings - due date extended to allow further data critique.
Review options to introduce Diagnostic utilisation into Control Room	K. Foster-Greenwood	~~30.06.25~~ 31.08.25		Jul 25: Diagnostic scoping complete. Options to identify capacity to commence a Diagnostic Control Room are being explored
Scope mutual aid and outsourcing options across L&SC	K. Foster-Greenwood	31.08.25		Jul 25: New action identified. Echo, Cardiac CT and non-obstetric ultrasound being scoped.
NHSE Cardiac Improvement Programme review to support improvements	K. Foster-Greenwood	31.08.25		Jul 25: New action identified.
Complete the build and mobilisation of additional endoscopy space	K. Foster-Greenwood	31.10.25		Jul 25: Capital build is ongoing. Unresolved issue re activity funding – escalated to the ICB. Revenue recourse case has been presented to PAG 03/07/25 and will be reviewed at Trust Management Board 16/07/25.

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

The following 2025/26 corporate objectives are aligned to the **People** strategic objective:

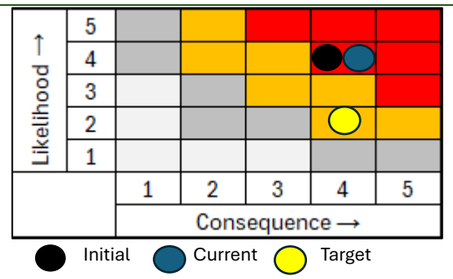
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO9	To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	• To deliver a workforce plan that responds to commissioning intentions and the communities we serve. • Achieve the headcount reduction needed to ensure successful delivery of the waste reduction workforce plan whilst maintaining safety.	Risks identified
CO10	To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	• To ensure staff choose to stay and work in Lancashire Teaching Hospitals and they are healthy at work. • Delivery of the People Plan. • To progress staff advocacy scores relating to provision of care. • To deliver the sexual safety charter within the organisation.	Risks identified
CO11	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care. • Deliver the Equality Diversity and Inclusion strategy. • To demonstrate we are an Anti-Racist Organisation.	Risks identified
CO12	To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.	• Leaders at all levels recognise their contribution to creating a culture where colleagues feel, ○ Together we are one team ○ Together we can create your future ○ Together we make extraordinary things happen • We will all strive to demonstrate our 'shared responsibilities' in the way we interact with one another.	No risk identified
CO13	To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	• To enhance the governance and leadership within the Board of Directors through the provision of a Board development programme. • To invest in the development of the senior leadership team within the organisation. • To support the development of leaders at department level through the delivery of leadership training and education.	Risks identified



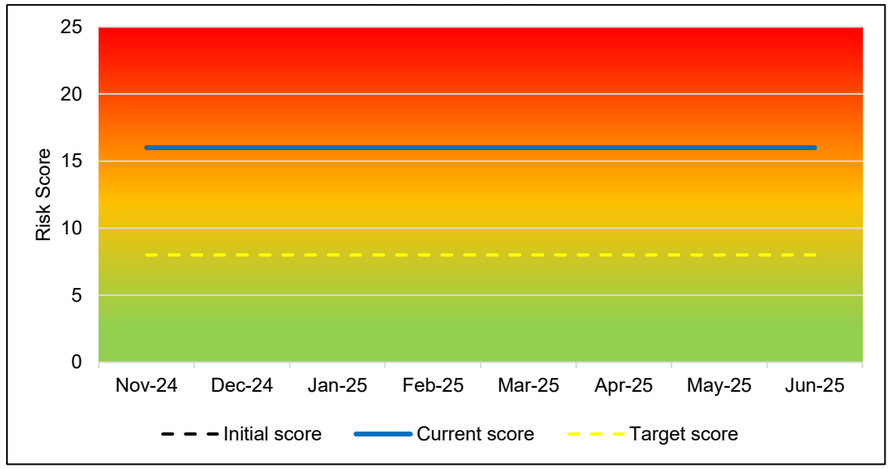
Heat map key: Black = current score, Blue = target score

Strategic Objective: People	**Corporate Objective:** To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	Overall Assurance Level	Medium

Principal risk 7 (25/26) (ID 2105)	Risk Title:	Reliance on temporary medical workforce		
	Risk Description:	There is a risk that there may be insufficient numbers of medical staff across the Trust. This is due to increasing capacity and demand, and an inability to recruit to vacancies in some specialities. This could result in a reliance on temporary medical staff, lack of continuity of care, patients not receiving treatment in a timely way, poor outcomes, patient harm, lack of detailed organisational knowledge of processes, poor patient and staff experience, staff working extra hours and an impact on wellbeing, financial impact of enhanced payment rates, regulatory enforcement, legal action and reputational impact.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	27/06/25	
		Target control date	31/08/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

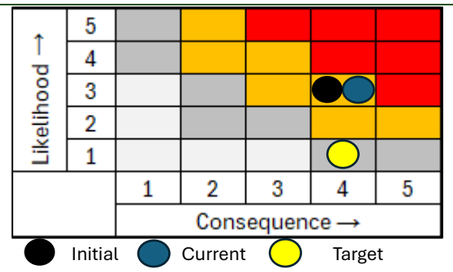
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Medical Annual Leave policy in place. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Daily Management System in place to aid understanding of temporary workforce in a timely manner. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Healthroster not fully aligned to job plans and when job plans are changed. • Operational capacity and technical ability to monitor 42-week productivity against job plans. • Vacancies in hard to recruit specialities can cause long gaps. • Understanding of speciality-by-speciality minimum safe staffing levels. • Sufficient resource to deliver transformational medical staffing projects. • Monitoring of actioning of Medical Annual Leave policy. • Retrospective additions of bank/agency shifts can be misleading for the Daily Management System	<u>Level 1 Assurance</u> • Monthly processes in place to review opportunities based on pay activity. • Monitoring of patients seen by a clinician within 14 hours of admission. • Monitoring of patients seen by a clinician following initial assessment. • Utilisation of agency medical staff reported to Temporary Staffing & Rostering Group each month. <u>Level 2 Assurance</u> • Annual Job plan report to Workforce Committee. • Quarterly medical safe staffing report to Safety & Quality Committee. <u>Level 3 Assurance</u> [None detailed]	• Delays in patients accessing senior medical reviews consistently in all specialties • Inability to articulate the required medical staffing model. • Inability to report on safe staffing levels in relation to medical staffing in response to CQC must do • Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software. • Requirement to strengthen consistency between ledger and vacancies. • Reports do not readily differentiate short term bookings from long term agency/bank staff.

Risk Treatment

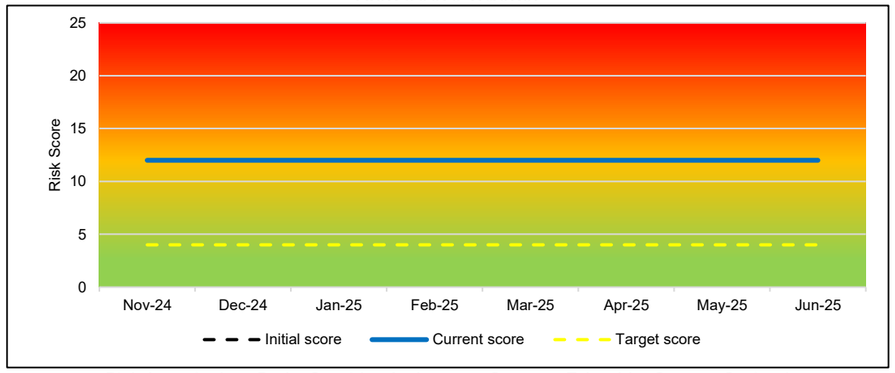
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree an approach to determining minimum safe staffing levels	G. Skailes	30.06.25	27.06.25	Jun 2025: Deputy CMO identified as lead. Position report and proposed approach presented to Safety & Quality Committee in June 2025.
Development of 42-week productivity tool	~~G. Skailes~~ M. Stewart	~~30.06.25~~ 31.07.25		Jun 2025: Current systems inadequate to report on this paper. Paper describing requirements to report on 42-week productivity to be taken to Planning Advisory Group. On hold until system improvements in place.

Strategic Objective: People	**Corporate Objective:** To be consciously inclusive in everything we do	Overall Assurance Level	Medium

Principal risk 8 (25/26) (ID 2110)	Risk Title:	Experience of staff, with specific focus on under-represented staff groups	
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust, including those in under-represented staff groups. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.	
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	27/06/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

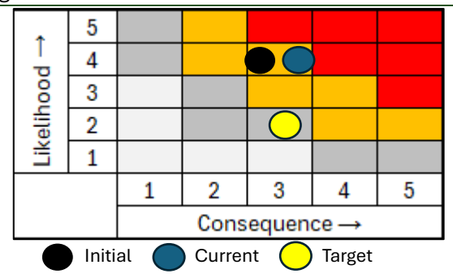
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Our People Plan • Corporate level action plan in response to NHS Staff Satisfaction Survey results. • Team Engagement and Development (TED) Tool and toolkit, supporting leaders to take local action to improve levels of engagement and satisfaction. • Equality, Diversity and Inclusion Policy. • Equality, Diversity and Inclusion Strategy. • Single Improvement Plan. • Equality, Diversity and Inclusion mandatory training. • Supporting Disability in the Workplace policy and agreement. • Trans and non-binary policy. • Equality Impact Assessment policy. • NHSE 8 High Impact Actions. • NHS People Promise. • Culture programme, including Zero Tolerance campaigns. • Freedom to Speak Up Policy, Process and Champions. • Employee Relations policies and processes. • Trust Values/Best Version of Us/Leadership in Lancs frameworks. • Core People Management Skills programme. • EDI resources/education/toolkits • Leaders/All Colleague briefings • Staff ambassador forums for colleagues with protected characteristics.	• No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. • ESR Declaration rates for colleagues with a long-term condition or disability. • EQIA process/lack of challenge in respect of EIA findings. • Gaps in localised application of inclusive management practices and in addressing poor behaviours which are not inclusive. • Awaiting mandates and directives following the High Court ruling with regards to protected characteristics of sex in April 2025.	<u>Level 1 Assurance</u> • Equality Diversity and Inclusion Annual Report • Suite of NHS Staff Survey reports and corporate level action plan. • Monthly reporting of participation with TED Tool. • Quarterly reporting of National Quarterly Pulse data. <u>Level 2 Assurance</u> • L&SC ICS ED&I Group. • Equality, Diversity and Inclusion Strategy monitoring. • Our People Plan Strategy Monitoring. • Single Improvement Plan reporting. • Workforce Committee. <u>Level 3 Assurance</u> • Internal Audit review of ED&I in 2023/24 – Substantial Assurance. • Some positive areas identified in the Workforce Race Equality Standards (WRES). • Some positive areas identified in the Workforce Disability Equality Standards (WDES). • North West Anti-Racist Framework. • EDS2022 • North West ED&I Assurance template	• Challenges in ability to drill down into the NHS Staff Satisfaction Survey data from a minority group/divisional basis due to low numbers and confidentiality. • Areas for improvement identified in the Workforce Race Equality Standards (WRES). • Areas for improvement identified in the Workforce Disability Equality Standards (WDES). • WRES/WDES report only completed on an annual basis • Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) • Ability to measure progress in Divisions and Departments with regard to actions taken to address lower levels of staff satisfaction and engagement. • Ability to drive up completion of the National Quarterly Pulse, to enable reporting to be more representative of the workforce.

Risk Treatment

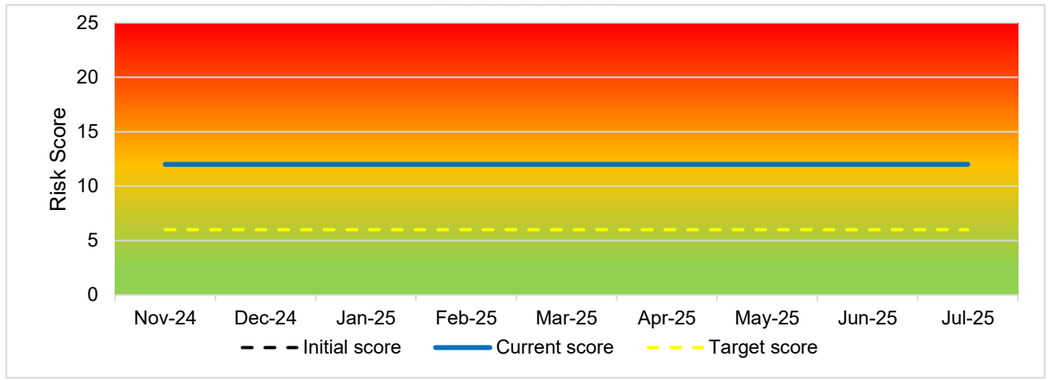
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Reducing the % of colleagues who have not declared disability status on ESR (annual measure)	M. Davis / R. Smith	30.05.25	30.05.25	Jun 2025: Reports presented at Workforce Committee in May 2025 and then at Execs also. The % of our workforce who have disclosed an LTC/disability has increased year on year (2023 – 4.8%, 2024 = 5.5%, 2025 = 5.7%), meaning the % of colleagues not declaring has reduced.
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	31.07.25		
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment	M Davis	31.07.25		
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics	M Davis	31.07.25		
Development of a refreshed colleague engagement offer	S. Kenny	31.07.25		Jun 2025: New action identified
Increased use of TED	S. Kenny	31.03.26		Jun 2025: New action identified
Delivery of actions in NHS Staff Survey Action Plan	S. Kenny	31.03.26		Jun 2025: New action identified

Strategic Objective: People	**Corporate Objective:** To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	Overall Assurance Level	Medium

Principal risk 9 (25/26) (ID 2111)	Risk Title:	Sub-optimal experience of Resident Doctors		
	Risk Description:	There is a risk that resident doctors experience of working at the Trust may not always be positive. This is because of operational pressures and working practices. This could result in poor staff experience, grievances, absence, a reduced level of medical staff, inability to recruit, patient safety incidents, regulatory intervention and reputational damage.		
Committee	Education, Training and Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	29/07/25	
		Target control date	31/08/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

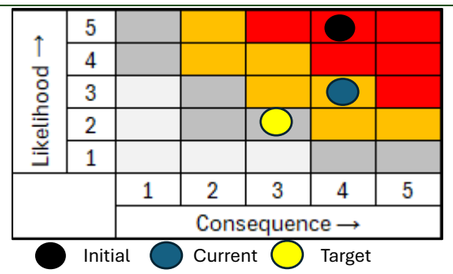
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Workforce and OD Strategy. • Education and Training Strategy. • Divisional education contracts. • NHS Education Contract. • Medical Workforce team.	• Lack of national guidance on "Improving the working lives of doctors in training". • National requirement to take an NHS Staff Survey approach to the GMC National Training Survey. • StatMand training currently under review for all staff groups including resident doctors. • Requirement to work with Lead Employer who holds employment responsibilities for resident doctors. • Time restriction of Lead Medical Education officer to progress the resident doctor agenda. There is a need to identify an accountable officer for responsibility of improving the working lives of doctors	<u>Level 1 Assurance</u> • Resident doctor forum. • Divisional Workforce Committee. • Raising Concerns Group. • Enhancing Doctors Working Lives Action and Assurance Group. <u>Level 2 Assurance</u> • Education, Training and Research Committee. • Workforce Committee. <u>Level 3 Assurance</u> • NHSE Monitoring the Learning Environment quarterly meetings. • GMC National Training Survey (NTS). • National Education and Training Survey. • Annual Internal Placement Experience. • De-escalation of concerns monitored via NHSE Intensive Support Framework (category ISF 1).	• Gap in triangulation of GMC National Training Survey into Raising Concerns, Exception Reporting and NHS Staff Survey Reporting • GMC National Training Survey 2024 results indicated that Trust performance is marginally below the national average in 14 out of 18 themes. • A number of areas of Post Graduate Medical Education are currently being monitored within the NHSE Intensive Support Framework, these include: 1) Senior Support for Foundation Doctors and Acting Beyond Competencies at CDH (ISF 1) 2) Efficient handover with clear allocation of roles (ISF 1) 3) GMC NTS 2024 Results showed Neurology RPH, Radiology RPH, Clinical Oncology RPH and Obstetrics and Gynaecology RPH in ISF 1. • Lack of NHS Staff Survey level of analysis and corporate level action plan for GMC national training survey and National Education and Training Survey for resident doctors, with insufficient triangulation of themes and organisational and specialty level.

Risk Treatment

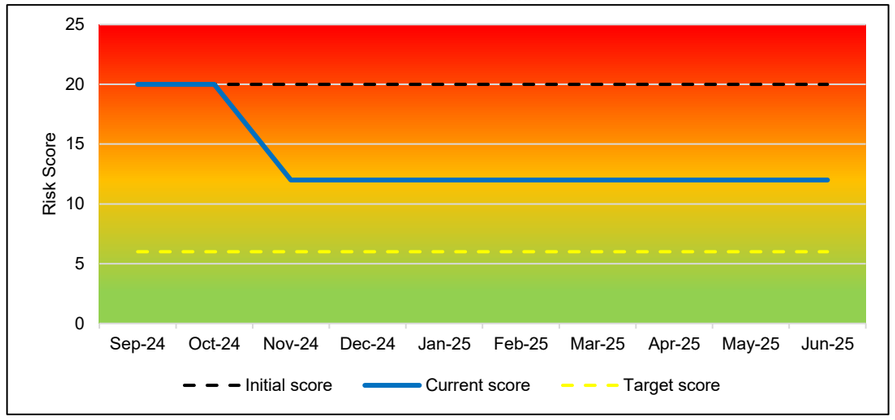
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Develop escalation protocols and guidance to provide senior support for foundation doctors and residents acting beyond competencies	M Brady	31.07.25	31.07.25	Jul 25: Individual CDH teams now have formalised escalation plans. Next steps are to share good practice across all LTHTR teams.
Undertake review of the handover template from RPH to test utility at CDH	H Bhaskar	31.07.25	31.07.25	Jul 25: New handover process established. Next steps are to embed the template into electronic patient records.
Review Education and Training Strategy	L. O'Brien	~~31.08.25~~ 31.12.25		Jul 2025: An annual strategy update will be presented to ETR in August 2025. Delays in the publication of the Trust Strategy , as well as the publishing of a 10-year plan from NHSE will impact on future Trust Education and Training Strategy. Due date extended.
Receipt and review of GMC Survey results to understand assurance around controls in place – expected end of July 2025	L. O'Brien	31.08.25		Jul 25: GMC survey results received and initial findings will be presented to ETR in August 2025.
Implement education portfolio changes to provide dedicated support to Medical Education	L. O'Brien	30.09.25		May 25: Due to unforeseen workforce related challenges, this work has been delayed. New expected implementation date is September 2025.
GMC Survey results to be reported to Enhancing Doctors Working Lives Action and Assurance Group to enable triangulation of themes	L O'Brien	31.08.25		Jul 25: New action identified
NHS Staff Survey level of analysis and corporate level action plan for GMC survey to be presented to ETR in October	L O'Brien	31.10.25		Jul 25: New action identified

Strategic Objective: People	**Corporate Objective:** To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	Overall Assurance Level	Medium

Principal risk 10 (25/26) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates		
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	10/02/14	Date of last review	26/06/25	
		Target control date	31/10/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

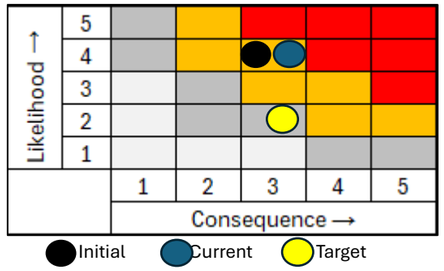
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Sickness Absence Policy in place. • Core People Management Skills training in place. • Monthly reports to Divisions - check & challenge. • Accountability Framework in place which has recently been refreshed. • Toolkits and templates for Managers. • "What Good Looks Like" for Managers. • Live data & reports in Health Roster. • Workforce Advisor Support in place (although at an insufficient level) • Health & Wellbeing Strategy in place. • Workforce & Organisational Development Strategy in place. • Operational processes in place Divisionally to look at staffing levels. • Dashboards in rosters to see safe staffing levels. • Rostering guidance and support in place.	• Gaps in localised management practices. • Lack of one complete absence record affecting ability to demonstrate policy compliance. • Insufficient capacity within the Workforce team to support absence management as proactively as possible. • Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. • Lack of triangulated data to support prediction/notice of warning signs for sickness absence. • Insufficient capacity within the psychological wellbeing service. • Development of mechanisms to prevent additional work/shifts which are counterintuitive to sickness absence position.	<u>Level 1 Assurance</u> • Divisional Workforce Committees. • Sickness absence reports are produced on a monthly basis which enables trend analysis of absence rates at cost centre level. These are reported through divisional workforce committees. • The Workforce team have undertaken local audits of absence management practice e.g. Return To Work Interview compliance. <u>Level 2 Assurance</u> • Workforce Committee. • Divisional Improvement Forums review absence levels. <u>Level 3 Assurance</u> [None detailed]	• Currently a manual process to monitor compliance with absence management policy and processes. • Inability to achieve the 4% target. • Internal audit of sickness absence management practices, (October 2024) provided limited assurance.

Risk Treatment

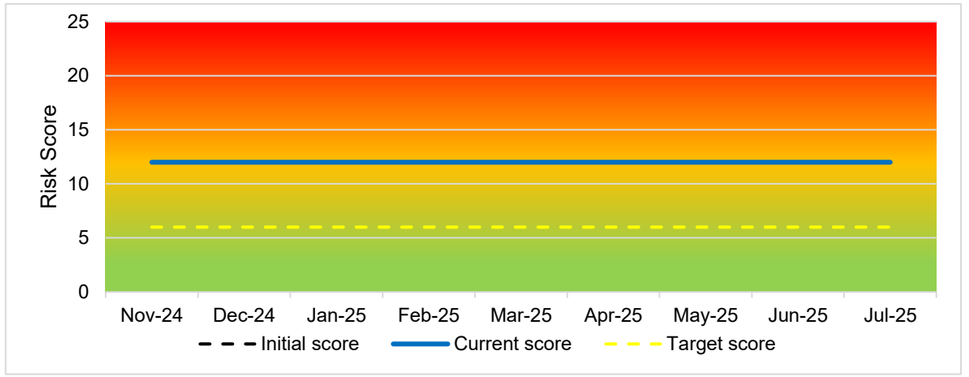
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	~~30.06.25~~ 31.12.25		June 2025: All actions continue to be progressed, however we are experience significant staffing pressures in the Workforce Advice team which is hindering pace. 2 new Workforce Advisers are at pre-employment stage, and we are seeking approval to recruit a further 2 to cover maternity gaps. Recruitment to the additional Psychologist post is live and 2 Occupational Health Physiotherapists have also been appointed, the first commencing on 30th June.
Pilot Empactis as a digital absence management system	R. O'Brien	~~31.07.25~~ 31.08.25		June 2025: Contract signed. Project Kick Off meeting with Empactis 30th June. Aiming to implement the 'Absence Manager' model across all pilot areas by end of August 2025.
Launch Rapid Access policy for expediting staff treatment	R. O'Brien	31.07.25		June 2025: New action. Rapid Access Policy agreed following discussion at Senior Leadership Team and will go to the Policy Ratification Group on 8th July 2025.
Introduce restrictions on additional hours following sickness	R. O'Brien	31.07.25		June 2025: New action. Updates to the Overtime and Attendance Management Policies made and will go to the Policy Ratification Group on 8th July, enabling implementation.
Benchmarking of absence reduction practice	R. O'Brien	31.07.25		June 2025: New action. Colleagues from NHS England who are leading on sickness absence reduction will be reviewing our strategies and advising of any gaps when benchmarked to best practice in other organisations.
Introduce Occupational Therapist into Occupational Health model	R. O'Brien	30.09.25		June 2025: New action. An investment case is being compiled.

Strategic Objective: People	**Corporate Objective:** To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	Overall Assurance Level	Medium

Principal risk 11 (25/26) (ID 2041)	Risk Title:	Compliance with Core Skills Training & Appraisals		
	Risk Description:	There is a risk that staff may not have received the core skills training required for their role or had an appraisal in the Trust-defined timeframes. This is due to unavailability of staff, time and capacity. This could result in staff not having up to competencies, patient safety incidents, poor patient experience, poor staff experience, regulatory action, claims and complaints.		
Committee	Education, Training & Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	29/07/25	
		Target control date	30/09/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Core skills training framework (CSTF). • Training needs analysis. • Corporate Induction process. • Local Induction process. • Appraisal Policy. • Appraisal Policy for Medical and Dental colleagues. • Accountability Framework. • Self-service e-learning and appraisal platform. • Regular review of target audiences with Clinical Educators and Divisional leadership. • Training Compliance and Assurance Sub-Committee govern any proposed changes to Core Skills topics. • Monthly emails to staff to show compliance with training and appraisals and any areas that are due to expire. • Weekly reminder to staff who are out of date with Core Skills training. • 'Super red' tool produced to support the divisions in identifying staff who have more than 1 super red topic. • Monthly meetings take place between Training Performance and Compliance and Divisional Nursing Directors to review target audiences and complete approval for sign off of any changes. • Training reports map directly to CQC core services, by professional group.	• Gaps in localised application of appraisal policy and processes. • Nationally set Core Skills training framework. • National review of Core Skills Training Framework (CSTF), which is reviewing statutory and mandatory training across all Trusts, with a plan to produce a national StatMand framework in 2025. This could increase / change the requirements for delivery of training nationally and the governance processes.	<u>Level1 Assurance</u> • Training & Appraisal Compliance report - produced monthly and sent to divisional and corporate leaders. • Regular provisions and/or presentation of compliance including Core Skills training report to Divisional Workforce Committees. <u>Level 2 Assurance</u> • Reports to Training, Compliance and Assurance sub-committee. • Training and Appraisal reports to Divisional Improvement Forums. • Bi-monthly Education Training and Research committee reports to escalate gaps and assurances in plans to rectify. • Annual Appraisal Strategic Update report to Workforce Committee. <u>Level 3 Assurance</u> • Integrated Board Performance Report. • NHS Staff Survey Results	• The Trust is currently non-compliant with specific mandatory (core skills training framework) & essential training subjects as reported to ETR Committee.

Risk Treatment

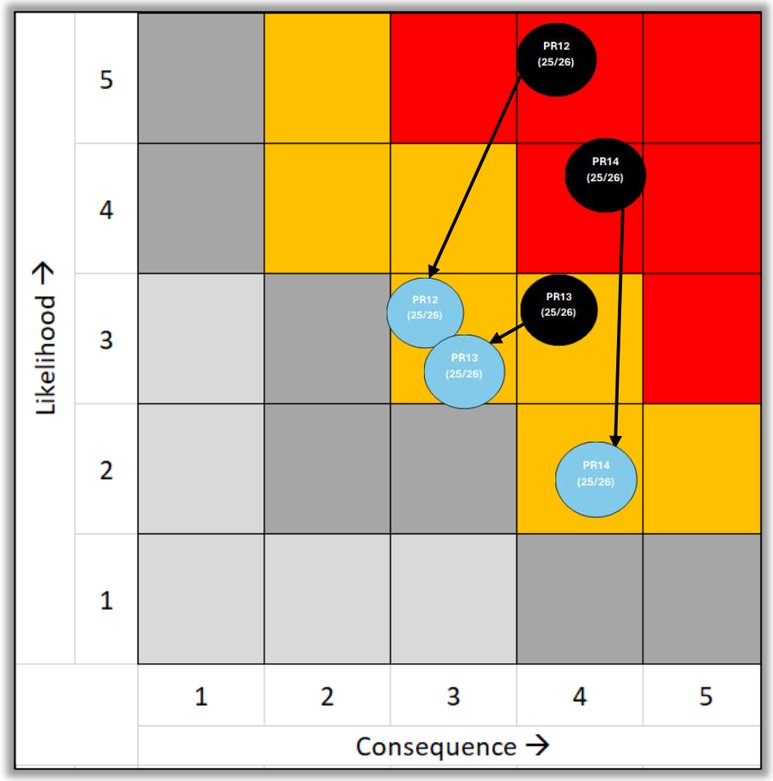
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Reviewing processes including guidance provided on how to complete appraisals, reviewing appraisal forms, monitoring and QA processes and developing intranet information hub.	L. Graham	~~31.07.25~~ 30.09.25		Jul 2025: The appraisal templates have now been reviewed and new guidance drafted. A new 'centralised close' standard operating procedure has been developed and implemented. The quality assurance process has been reviewed and decision made to cease as it delivered limited impact. In its place will be increased appraisal data analysis provided to Divisional Workforce Committees on a biannual basis, this will include assessments of overall appraisal compliance, appraisal ratings, talent management ratings, number of objectives and objective completion, personal development themes and completion this will enable richer discussions and targeted action to be taken. This action has not yet been implemented, as work continues to be stalled due to vacancies in Organisational Development team and existing capacity is prioritised for alternative streams of work. Due date extended to allow for remaining sub-actions to be completed.
Review Mandatory Training Policy	L. O'Brien	30.09.25		Jul 25: Policy and associated Procedures peer reviewed and ratified by the Training Compliance and Assurance Sub-Committee in July 2025. Scheduled for Procedural Documents Ratification Group on 12 Aug 2025
Develop actions to address persistent non-compliance with mandatory training	L O'Brien	31.08.25	30.07.25	Jul 25: Paper outlining actions proposed to address persistent non-compliance with Core Skills and Mandatory Training presented to Workforce Committee on 8 Jul 2025. Trustwide communications prepared outlining the formalised process of escalation reminders

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

The following 2025/26 corporate objectives are aligned to the **Productivity** strategic objective

Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO14	To provide value for money services by spending less, spending well and spending wisely	• To evidence improved value for money and delivery of the financial recovery programme • To design services that are affordable and deliver within the budget. • Commit to make the best use of finance and colleague contribution.	Risks identified
CO15	To deliver sustained improvement evidenced through the single improvement plan	• To deliver against the plan and demonstrate improved outcomes for the organisation • Launch the Lancs Improvement Method	No risk identified
CO16	Improve our underlying productivity and efficiency	• To maximise our productivity through the deliver of the Waste Reduction Programme, Single Improvement Plan and other transformation plans	No risk identified
CO17	To develop a clinical services strategy for the organisation	• To develop safe, innovative, sustainable and affordable clinical models for the future	No risk identified

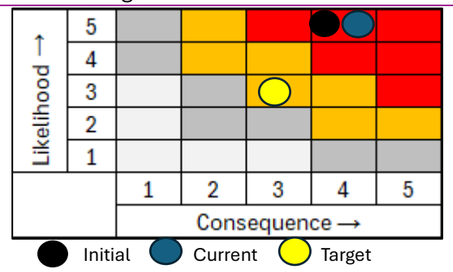


Heat map key: Black = current score, Blue = target score

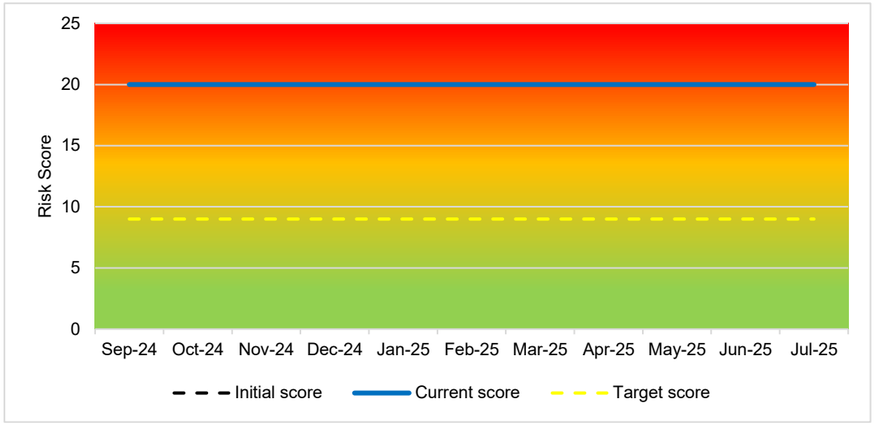
Strategic Objective: Productivity	**Corporate Objective:** Provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 12 (25/26) (ID 1557)	Risk Title:	Failure to meet the financial plan in 2025/26	
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2025/26. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, inability to exit NHS Oversight Framework (NOF) level 4, further regulatory intervention, impact on staff experience, and reputational damage.	

Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	10/07/25
		Target control date	31/03/26



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

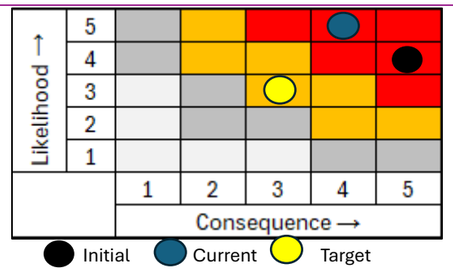
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. • Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. • There are a suite of pay controls for filling vacancies and using agencies. • Processes are in place to ensure waste reduction programme (WRP) schemes that are delivered are transacted through the ledger. • There are a range of grip and control measures in place for managing discretionary expenditure. • There is a no PO no pay system in place for managing non pay expenditure.	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • The savings programme alongside additional control measures is not delivering the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 25/26. • PMO to support the divisions to deliver the WRP is being finalised with external support. • Operational pressures limiting management capacity.	<u>Level 1 Assurance</u> • Ledger reconciliations - on the integrity of the financial data. • Variance and trend analysis - on the integrity of the financial data. <u>Level 2 Assurance</u> • Risks identified monthly to Finance and Performance committee. • Internal Audit - on the integrity of financial systems - through Audit Committee. <u>Level 3 Assurance</u> • Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. • External Audit - on the financial accounts - through Audit Committee. • Collaborative working in ICS - integrity of financial data.	• WRP schemes are not fully developed for 2025/26 schemes (c. 83% fully developed). • The Trust did not deliver the identified financial plan for 2024/25. The deterioration of forecast in-year resulted the Trust being escalated to national oversight framework (NOF) level 4 and being enrolled in the recovery support programme (RSP). • Assessment of the Trust's actions in response to PWC grip and control review require external assessment to confirm completion. • External financial governance review identified some areas to strengthen.

Risk Treatment

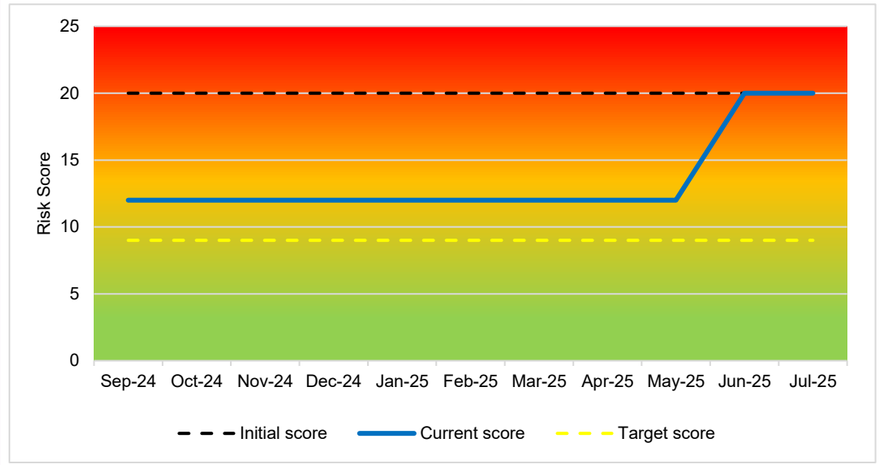
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Business Case to review/finalise the recurring resources needed for Trust project management office.	A. Brotherton	31.05.25	12.05.25	May 2025: Business case approved, consultation due to be finalised at the end of May and the new PMO formed (minus vacancies in the team) from June 2025.
Fully identify all schemes to support the 2025/26 Waste Reduction Programme (WRP)	C. Carter	31.05.25	31.05.25	Jun 2025: All schemes identified in May by the required date
External support obtained until end of Quarter 1 to further develop schemes and support programme management capacity	C. Carter	~~30.06.25~~ 31.08.25		Jul 25: All schemes have now been identified. External support has been extended to the end of August until the Trust's PMO is fully operational. The aim is to move all identified schemes to fully developed by the end of August 2025 as agreed with the Improvement and Assurance Group (IAG).
Internal audit assessment of grip and control actions and Trust's current position	C. Carter	30.09.25		Jul 25: Self-assessment completed. Internal Audit awaited.

Strategic Objective: Productivity	**Corporate Objective:** To provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 13 (25/26) (ID 802)	Risk Title:	Cash consequences of the Trust's underlying financial position	
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	10/07/25
		Target control date	30/09/25



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

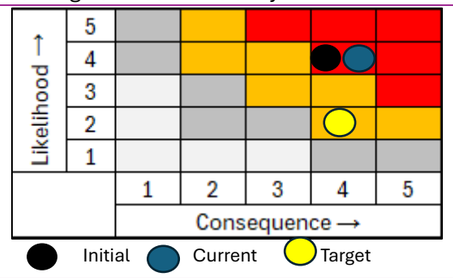
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts.	• Levels of understanding of the cash consequences of not using the established ordering processes. • Access to cash support is subject to external approval.	<u>Level 1 Assurance</u> • Monitoring and reporting performance against 30-day deadline for payments. <u>Level 2 Assurance</u> • Internal Audit reporting through Audit Committee. • Monthly reporting of position including KPIs to Finance & Performance Committee. <u>Level 3 Assurance</u> [None detailed]	• Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. • Drop in performance against 30-day deadline for payments.

Risk Treatment

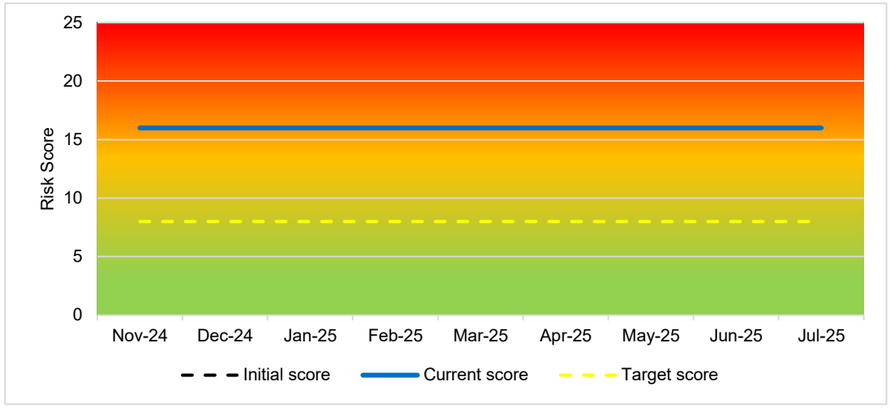
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	~~31.07.25~~ 30.09.25		Jul 25: The Trust remains in a position where case may become limited beyond August 2025. A paper was taken to the Board of Directors giving an update on the current cash situation, requesting permission to seek funds in September 2025. The risk score was escalated in June 2025 and the Chief Finance Officer is liaising with NHS England as to the potential risks associated with the non-approval of the request, to ensure that we are taking all necessary steps to mitigate this risk.

Strategic Objective: Productivity	**Corporate Objective:** To provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Medium

Principal risk 14 (25/26) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate		
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas of the Trust's ageing estate. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 8-12	
Director	Chief Finance Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	10/07/25	
		Target control date	31/03/26	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • A balanced Capital Plan for 2025/26 has been agreed. • Capital Planning Forum review and determine risk-based approach and recommendations. • Capital Plan agreed by Executive Team & Trust Board. • Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. • Medical Equipment Group with clinical input to support risk assessment and prioritisation. • IT provided with a budget from Capital Planning forum. • Contingency budget identified at the start of the financial year. • Emergency capital funding process for extreme situations. • Identification of national funding 'bid opportunities'. • Standing financial instructions. • Standing Orders. • Scheme of Reservation and Delegation.	• Externally set capital allocation. • External capital bid opportunities have short timeframes and ability to fully cost this is limited by operational capacity. • Impact of inflation in terms of project costs and timescales. • Ageing estate and inability to comply with latest statutory guidance. • Estates Strategy not finalised. • Approach to IT allocations requires review. • Inability to replace medical equipment as required.	<u>Level 1 Assurance</u> • Asset register in place to support oversight of medical equipment. <u>Level 2 Assurance</u> • Medical Device report to Safety & Quality Committee. • Capital update to Finance & Performance Committee. <u>Level 3 Assurance</u> • 6 facet survey and independent annual report which details the scope and level of the situation. • Estates Returns Information Collection (ERIC) returns to support benchmarking.	• Significant backlog maintenance. • Tracking of project overruns and underspend. • Governance around contract change notices. • Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind).

Risk Treatment

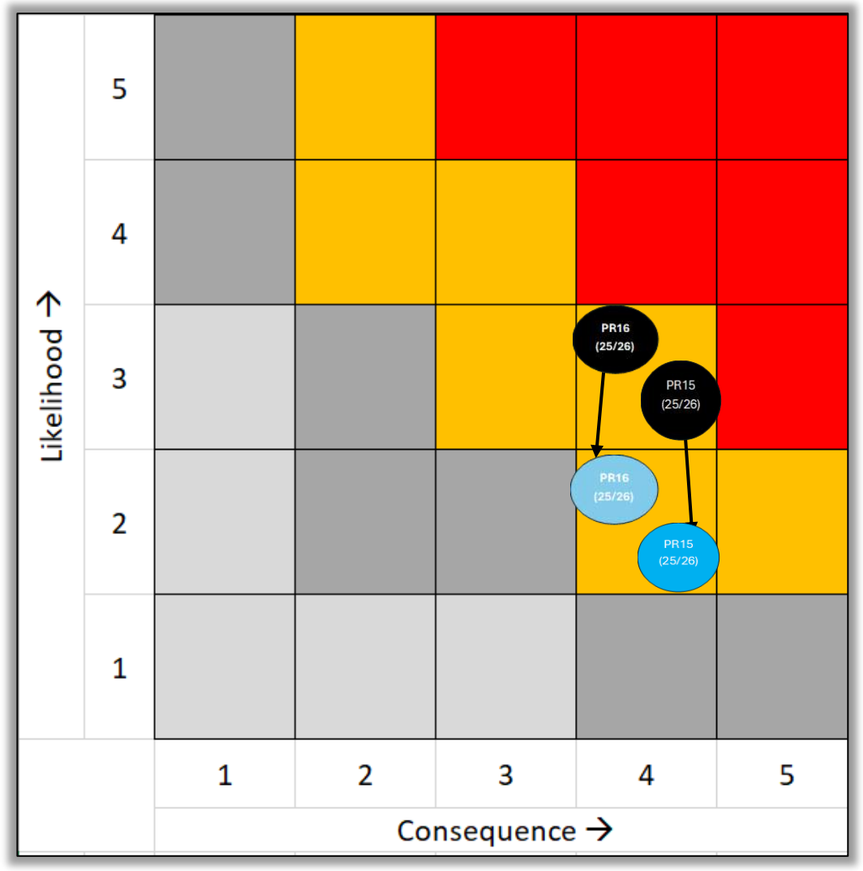
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Develop Estates Strategy	C. Howell	~~30.07.25~~ 30.11.25		Jul 25: There has been a pause to this to reflect on next steps following the NHP delay, which was announced on 20.01.25. Clinical Strategy will require some re-writing alongside the Estates Strategy. Updated estimated timeframe for the re-write of the Estates Strategy is Autumn 2025.
Review approach to management and reporting of project spend at Capital Planning Forum	C. Carter	31.07.25		Jul 25: Template being produced for project updates.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2025/26 corporate objectives are aligned to the **Partnership** strategic objective:

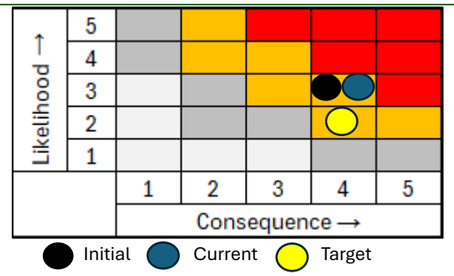
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO18	To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.	• Develop and launch the Trust strategy in collaboration with partners. • Develop the capital plans to support the transition. • Develop a digital programme to support the workforce reduction. • Communicate plans with internal and external stakeholders.	No risks identified
CO19	Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.	• Deliver plans for OneLSC and develop and implement agreed clinical service strategies/plans. • As an Anchor Institution, work with partners to improve population health, supporting development of a thriving local economy and reducing health inequalities. • Reduction in demand through development of Neighbourhood Health with specific focus on frailty and end of life management in central Lancashire.	Risk identified
CO20	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status • Continue to shape an education, learning and innovative culture	Risk identified
CO21	Working with partners, create a single pathology service	• To develop and implement the detailed plan for a single pathology service. • Work up the Capital Business Case for a single Pathology hub.	No risks identified



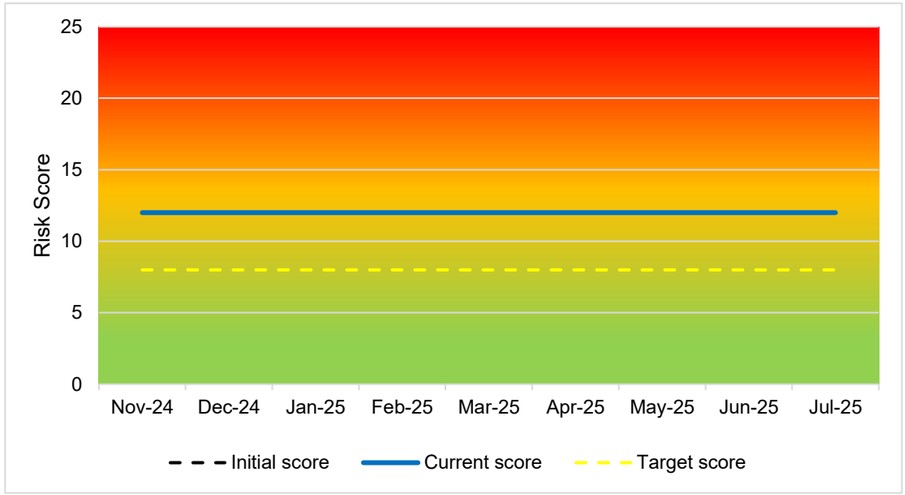
Heat map key: Black = current score, Blue = target score

Strategic Objective: Partnership	**Corporate Objective**: To make progress towards our ambition to be a University Teaching Hospital	Overall Assurance Level	Medium

Principal risk 15 (25/26) (ID 2113)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status		
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.		
Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12	
Director	Chief Strategy and Improvement Officer, and Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	29/07/25	
		Target control date	31/12/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Fixed National Institute of Health & Care Research (NIHR) Income. • Research & Innovation Strategy (2022-25). • Some protected job-planned time for clinical research activity. • Quarterly Research Collaborative meetings with the 2 main LSC universities to develop research opportunities. • Some joint appointments with university partners.	• Historical and current overspend of research budget. • Funding available to increase capacity and capability. • Ability to engage medical colleagues in in different academic specialities to support advances in research in those areas. • Strategy and appetite of universities to invest in clinical or other academic roles to be based at the Trust.	<u>Level 1 Assurance</u> [None detailed] <u>Level 2 Assurance</u> • Bi-annual Research & Innovation Strategy update. • Research & Innovation Committee. • Education, Training & Research Committee. <u>Level 3 Assurance</u> • Integral role in ICS R&I Collaborative.	• Income generation plan for financial recovery plan is behind trajectory. • Initial project plan to develop partnerships not currently agreed and therefore progress is not able to be reported to R&I Committee and ETR Committee. • Universities are experiencing similar budget constraints and so may lack ability to invest in these areas.

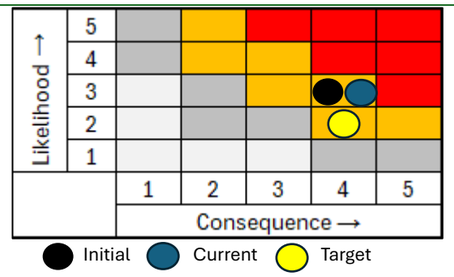
Risk Treatment

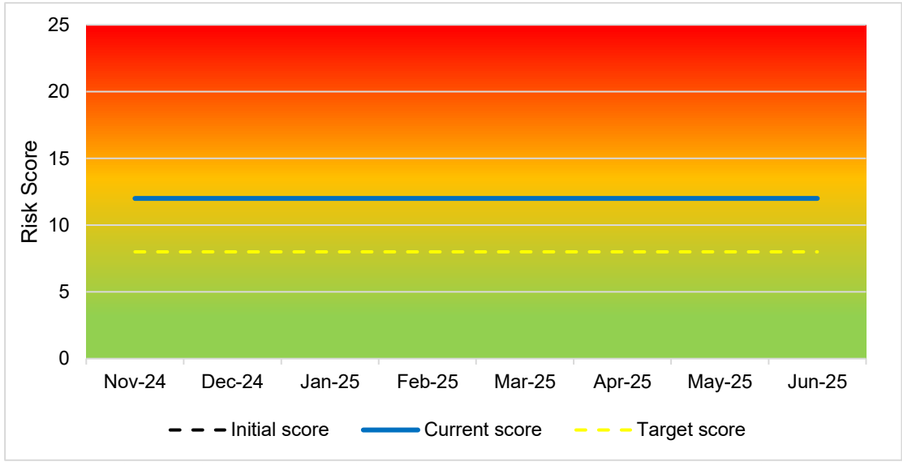
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown/ G. Skailes	31.08.25		Jul 25: The first project meeting has been held on 06.06.25 with a clear project plan still in aspiration. More detailed discussion with 2x university partners to be scheduled early Autumn. Initial plans for June meeting included thought on inclusion of specialties and potential supporting colleagues.
Have Research roles in place within 2 Divisions	P. Brown	01.10.25		Action transferred from strategic risk May 25. Research & Innovation has begun a restructure to allow greater flexibility in clinical teams and in which divisional alignment is central, initially to Medicine and Surgery – this is yet to be confirmed. Further work is required with Workforce colleagues thus the change to due date to 01/10/25, by which time it should be confirmed if it is realistic for some or all Divisions to appoint a lead on one PA.
Appointment of University of Lancashire joint posts to support the expansion of Undergraduate Medical placements at LTHTR	L. O'Brien	30.09.25		Jul 25: New action identified.

Strategic Objective: Partnership	**Corporate Objective**: Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.	Overall Assurance Level	Medium

Principal risk 16 (25/26) (ID 2107)	Risk Title:	Failure to progress the configuration of Trust services to enable the delivery of the clinical strategy for LTHTR and L&SC	
	Risk Description:	There is a risk that the configuration of services and implementation of the long term strategy for the Trust may be hindered because of lack of alignment with system partners, clear commissioning intentions, insufficient clarity/strength within our processes for system governance/change, resource limitations, and potential resistance to change. This could result in delays in achieving the objectives, fragmented service delivery, reduced quality of patient care, increased costs and inefficiencies across the healthcare system, and failure to improve health outcomes for the population.	

Committee	Finance & Performance	Risk Appetite and Tolerance	Seek 9-12
Director	Chief Strategy & Improvement Officer/Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	10/07/25
		Target control date	31/03/26





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire and South Cumbria (L&SC) Integrated Care System (ICS) joint NHS forward plan and Clinical Blueprint • Improvement & Assurance Group (IAG) in place and meeting monthly. • Three-year Single Improvement Plan • Trust's Annual Corporate Objectives • Provider Collaborative Board Joint Committee (PCB JC) • Place based working • Trust development/integration plans with LSCFT • First Recovery Support Programme (RSP) has been held. The RSP Team are engaging in observing Board and Sub-Board Committee meetings and work is underway to develop the programme of work needed (which will be incorporated into SIP). • A Working Group is established to develop the Preston Health Hubs, in line with the NHS 10-year Plan published in July 2025, and Trust members are actively contributing.	• L&SC Clinical Blueprint has been developed but we are not yet at the stage where we have a detailed, agreed implementation plan. • Discussions with external partners regarding greater service/pathway integration still need further development and may be impacted by the discussions/plans with respect to the L&SC Clinical Blueprint. • Trust long term strategy not yet finalised, but the aim is to present to October 2025 Board now the NHS 10-year Plan has been published in July 2025. • Draft ICB Commissioning intentions have been shared but more discussion needed to agree the implications for the Trust. • System based working is still evolving/improving e.g. the PCB Governance reset is underway but has not been fully implemented and Place based working is still developing.	<u>Level 1 Assurance</u> • Trust Board workshops/seminars <u>Level 2 Assurance</u> • Finance & Performance Committee system updates • Trust Board discussions/papers <u>Level 3 Assurance</u> • ICB and Regional NHSE Improvement & Assurance Group (IAG). • Recovery Support Programme (RSP) /Provider Improvement Programme (PIP)	• Finalised Trust long term strategy

Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree final Trust long term strategy	A. Brotherton	30.09.25		Jul 25: Long term plan has now been published alongside the Dr Penny Dash review and work has commenced to review these and incorporate the key recommendations/actions in our Trust Strategy. A Strategy Board Workshop has been arranged for 31st July 2025.

9. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY)

9.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Deeny | 10.00am

For Assurance

REFERENCES

Only PDFs are attached

9.1 - Chair's report - Safety and Quality Committee - 30 May 2025 & 27 June.pdf

Chair's Report to Board		
Chair: Non-Executive Director Dr Karen Deeny	Safety and Quality Committee	
Date: 30 May & 27 June 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• The Infection Prevention and Control Annual Report, the Patient Experience Annual Report and the PSIRF Annual Report were recommended for Board approval on 3 June 2025. • The Mortality Annual Report and Safeguarding Annual Report were endorsed by the Committee at the 27 June meeting. • The Bi-annual Nursing and Midwifery Workforce Review Report and the Quality Account were endorsed by the Committee at the 25 July meeting.

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**Never Events:** ○ Two reported in May (one in plastics, one in ophthalmology, noting this is the fourth never event in ophthalmology). ○ In response to the Never Event in ophthalmology, an immediate 48 hour pause within the service was enacted, an internal set of actions agreed, an internal forensic review undertaken and an external Royal College of Ophthalmology Review commissioned. ○ Non-Executive Directors supported a site visit and the internal forensic review. **Regulation 28** ○ A regulation, 28 Prevention of Future death notice was received regarding the risk of access to mechanical thrombectomy. The Committee noted this was an area of continued focus by the Executive that required a long term solution to be finalised. The response to this notice was due to the Coroner by 31 July 2025 and this would be scrutinised by the Committee was completed.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**The improvements for Tier 2 staffing within maternity services was leading to enhanced safety outcomes, including faster reviews of women presenting in the service. This development was also associated with financial benefits for the Trust, achieved through a well-structured business plan.** **Improvement plans had been implemented to address underperformance identified through the STAR audits, with the delivery of improvement targets anticipated by August 2025.** **A comprehensive update on Boarding and Continuous Flow, including actions taken and system contributions, was reported at the June Safety and Quality Committee.**

	The Committee endorsed the establishment of the Health and Safety single improvement plan workstream. This reflected the requirement to strengthen several areas relating to health and safety. **The Committee received a verbal update following the CQC visit to CDH, noting positive feedback in relation to culture, improvement approaches and wider observations. A formal letter with feedback will be shared in due course.** **Maternity Services – National Inquiry. The Committee confirmed that the self-assessment process in response to the national maternity inquiry recommendations would be reported through the Safety and Quality Committee. A letter and response plan were scheduled to be presented at the next meeting.**
ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to:** **Maternity and Neonatal Report** **Annual PSIRF Report** **Annual Patient Experience Report** **Infection Prevention and Control: Annual Plan inc Clostridium Difficile Deep Dive and NHSE BAF** **Thrombectomy specialised commissioning escalation** **Bi-annual Health and Safety Review** **Children and Young People Staffing** **Medical Staffing Report** **Annual mortality, LEDER and PMRT report** **Annual Safeguarding Mid-Year Report** **Annual Medicines Governance Report** **Continuous Flow and Boarding Process** **Children's Survey** **The reports provided an overview of areas of strength and areas that required continued focus.** **The Children and Young People report provided the Committee with clear visibility on the care provision for children and young people within the organisation.** • **The Committee endorsed and recommended Board approval for the Infection Prevention and Control Annual Plan, Annual Patient Experience Report, Annual PSIRF Report, Mortality Annual Report, Safeguarding Annual Report, Bi-annual Nursing and Midwifery Workforce Review Report and the Quality Account.**

	Children's Services at the CDH site received 'Getting It Right First Time' (GIRFT) accreditation, recognising excellence in clinical standards and patient care pathways. **Following a rare and tragic maternal death, the Committee reviewed the incident and received assurance that a rapid incident review process had been followed, ensuring sensitive and appropriate actions were taken.** **The Committee received the Medical Safe Staffing report and agreed to receive a follow-up report in September, which would include progress on risk mitigation and CQC feedback. This would support the development of robust assurance for medical staffing.** **An overview of the Continuous Flow Model and Boarding Process was presented to the Committee. The Committee acknowledged the rigour of the current approach and agreed that while assurance could be taken from the measures in place, further work was needed. It was agreed that updates would be provided on a bi-annual basis noting that escalations would be reported accordingly.** **The Committee endorsed the Annual Safeguarding Report, which outlined safeguarding activity and confirmed compliance with legislation.** **The Annual Medicines Governance Report provided assurance that medicines were managed safely, supporting effective, responsive and person-centred care.** **The Committee was assured by the results of the 2024 National Picker Children and Young People Survey and agreed to consider implementing an internal survey to monitor ongoing developments.** **The Committee welcomed the addition of explicit timelines and trajectories in reports and encouraged their continued use to enhance assurance.**

Safety and Quality Committee

30 May 2025 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 25 April 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	E Holden
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.20am	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	11.30am	✓	Assurance	E Ashton
7.3	Annual PSIRF Report	11.40am	✓	Assurance	H Ugradar
7.4	Infection Prevention and Control: a) Annual Plan inc Clostridium Difficile Deep Dive b) NHSE BAF	11.50am	✓	Assurance	D Orr C Gregory
7.5	Thrombectomy specialised commissioning escalation	12.05pm	✓	Assurance	G Skailes
8.	STRATEGY AND PLANNING				
8.1	Annual Patient Experience Report	12.20pm	✓	Assurance	C Gregory
8.2	Winter Plan – Committee Alignment	12.30pm	Verbal	Decision	K Foster-Greenwood
9.	GOVERNANCE AND COMPLIANCE				
9.1	Bi-annual Health and Safety Review	12.40pm	✓	Assurance	H Ugradar
9.2	Annual Quality Account	12.50pm	✓	Decision	H Ugradar
9.3	Strategic risk register review	1.05pm	Verbal	Decision	K Deeny
9.4	Items to alert, advise or assure the Board.	1.10pm	Verbal	Information	K Deeny

№	Item	Time	Encl.	Purpose	Presenter
9.5	Reflections on the meeting	1.15pm	Verbal	Assurance	K Deeny
10.	ITEMS FOR INFORMATION (matters to be raised by exception)				
10.1	Clinical Audit and Outcome Report		✓		
10.2	Children and Young People Report		✓		
10.3	Sub-contract monitoring assurance report		✓		
10.4	Never Event Notification – Incident no: 18982		✓		
10.5	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee – **stood down** e) Patient Experience and Involvement f) Health Inequalities Group – **stood down**		✓		
10.6	Date, time and venue of next meeting: *27 June 2025, 11.00am, Microsoft Teams*	1.20pm	Verbal	Information	K Deeny

Safety and Quality Committee

27 June 2025 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 30 May 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.10am	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard (including update on Ophthalmology Visit following recent Never Event)	11.20am	✓	Assurance	C Gregory
7.2	Medical Staffing Report	11.40am	✓	Assurance	M Stewart
7.3	Annual mortality, LEDER and PMRT report	11.50am	✓	Assurance	M Stewart
7.4	Annual Safeguarding Report	12.00pm	✓	Assurance	R Sansbury
7.5	Annual Medicines Governance Report	12.10pm	✓	Assurance	G Price
7.6	Continuous Flow and Boarding Process	12.20pm	✓	Assurance	R Sansbury
7.7	Children's Survey	12.25pm	✓	Assurance	S Morrison
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	12.35pm	Verbal	Decision	K Deeny
8.2	Items to alert, advise or assure the Board.	12.40pm	Verbal	Information	K Deeny
8.3	Reflections on the meeting	12.45pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	Children and Young People Report		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	Board Briefing on Ophthalmology Never Event		✓		
9.3	Board Briefing on Thrombectomy Regulation 28 Notice		✓		
9.4	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group – **stood down** g) Mortality and End of Life Care Committee h) Health and Safety Governance – no meeting		✓		
9.5	Date, time and venue of next meeting: *25 July 2025, 11.00am, Microsoft Teams*	12.50pm	Verbal	Information	K Deeny

9.2 *QUALITY ACCOUNT

Decision Item | H Ugradar | 10.10am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack.

REFERENCES

Only PDFs are attached

9.2 - Quality Account -August 2025.pdf

Board of Directors

Quality Account 2024/25							
Report to:	Board of Directors			**Date:**	7th August 2025		
Report of:	Chief Nursing Officer			**Prepared by:**	M Durkin/ H Ugradar		
Part I	☑			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒	**For information**	☐		

Executive Summary:

This report presents the Quality Account for 2024/25 for approval review by the Board of Directors. The Quality Account is a statutory requirement under the Health Act 2009, with further provisions introduced by the Health and Social Care Act 2012. It remains a key mechanism for NHS providers to demonstrate transparency, accountability, and a commitment to continuous improvement in the quality of care.

The Quality Account outlines the Trust's performance over the past year in relation to patient safety, clinical effectiveness, and patient experience, and sets out the Trust's quality improvement priorities for the year ahead. It includes both nationally mandated content and locally determined priorities, along with statements from key stakeholders such as the ICB Quality Assurance team and Healthwatch Lancashire, as part of the statutory consultation process.

Although NHS foundation trusts are no longer required to include the Quality Account within their Annual Report, NHS England continues to expect all eligible providers to produce and publish a standalone Quality Account in line with national guidance. This reflects the ongoing importance of public accountability and quality assurance in NHS services.

The Board of Directors received a presentation summarising the draft Quality Account for 2024/25 in June 2025. Since then, stakeholder feedback has been received and considered.

In line with requirements, the Quality Account was published on the Trust's website in early July 2025, with a caveat noting that it remains subject to formal Board approval.

The final version of the Quality Account was presented to the Safety and Quality Committee on 25 July 2025. The Committee has recommended it for Board approval.

It is now recommended that the Board approves the final Quality Account for 2024/25.

Appendix 1- Quality Account Summary presentation Appendix 2 – Quality Account	**The full report is included in the ancillary pack**

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Safety and Quality Committee – 25th July 2025

9.3 *ANNUAL SAFEGUARDING REPORT

Decision Item | S Morrison | 10.15am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

9.3 - Safeguarding Annual Report 2024-25 Final BOD.pdf

Board of Directors

Safeguarding Annual Report 2024 / 2025

Report to:	Board of Directors	**Date:**	7 August 2025
Report of:	Chief Nursing Officer	**Prepared by:**	A Hardyman – Head of Safeguarding

Purpose of Report

For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of the report is to provide an annual account of safeguarding activity. The report has been presented and scrutinised by the safety and quality committee. The report provides assurance of compliance with legislation, including The Children Act (1989, 2004,2014), The Care Act (2014), Mental Capacity Act [MCA] (2005,2014), Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act (MHA 1983, amended 2007). A glossary of terms is provided within Appendix 7 of this report.

The report demonstrates that demand and activity across the safeguarding agenda has continued to be high. Safeguarding team partnership, system working and shared learning across Lancashire and South Cumbria is in place. The report highlights that activity is driven by internal qualitative and quantitative data alongside the Lancashire and South Cumbria safeguarding agenda. The delivery of the safeguarding agenda and evidence of sustainability is also obtained by robust audit activity, demonstrating lessons learnt, and ensuring improvements are embedded in practice.

The Trust is compliant with the requirements of the NHS England (NHSE) Safeguarding Accountability and Assurance Framework (2019, updated 2024) and has submitted and evidenced compliance into the new NHS Provider Safeguarding Commissioning Assurance Toolkit (P-SCAT, Appendix 1). The Trust has evidenced full compliance in the Children's Safeguarding Assurance Partnership Pan – Lancashire Section 11 audit 2024-2025, for 9 of the 10 standards and partial compliance for the standard related to training. The standard that is partially compliant is a new requirement in 2024 for staff to be trained in trauma informed care. This is a focus for the 2025-2026 work plan, with 6 staff in the safeguarding team having completed the Train the Trainer course to support future roll out across the Trust. The safeguarding team have also promoted the Trauma Informed training which can be accessed via the Violence Reduction Network (VRN). The safeguarding team continue to ensure Trust participation in the NHSE Learning Disability Benchmarking Standards and National Audit of Dementia which informs service development.

Continuous improvement methodology drives the approach with the safeguarding team linked into several 'Big Rooms' (nutrition, de-conditioning, mental health, violence and aggression and Enhanced Therapeutic

Observation and Care (ETOC). The safeguarding team are involved in multiple Trust-wide service developments and activities to highlight key messages in relation to safeguarding (Appendix 2).

Overall, the report demonstrates a sustained improvement in the safeguarding adult and child position. The Trust is compliant with all elements of mandatory safeguarding training and has delivered improvements across the safeguarding agenda during 2024/25, some of which are detailed below:

- Significant progress with the Safeguarding Single Improvement Plan – aimed at improving the experiences of patients with a mental health, learning disability, autism and dementia, focused on reducing restrictive practices and equipping our work force with enhanced skills.
- The Section 42 Safeguarding investigation process has been refined with the local authority to ensure that all enquiries are logged as a Section 42 rather than initial fact finding. This has resulted in larger numbers; 74 in 2024/2025 in comparison to 41 in 2023/2024 with strengthened governance, sharing of information and opportunities for shared learning.
- Continued Trust wide assurance in the improved compliance for the completion of MCA/DoLS.
- Continued implementation of regular safeguarding supervision with recording of compliance via the annual appraisal system and implementation of supervision to wards/teams.
- Completion of audit activity across multiple areas to gain assurance in staff knowledge and compliance of processes in place.
- Strong assurance that screening is embedded for substance misuse in maternity. 100% of occasions women reporting substance use at the antenatal booking appointment were referred to the Enhanced Support Midwifery Team (ESMT) for complex care planning.
- Further commissioning of a contracted Independent Health Independent Domestic Violence Advisor (HIDVA), a Health Independent Sexual Violence Advisor (HISVA) and Emergency Department (ED) Navigator.
- High Intensity User service has demonstrated meeting the key performance indicator of a 20% reduction in non-elective attendances for patients in the service
- Strengthening of the Divisional Always Safety-First Safeguarding meetings providing escalation and assurance to the Safeguarding Board. The safeguarding agenda is also triangulated into the Patient Safety Incident Response Framework (PSIRF) and the Always Safety-First Learning and Improvement Group.
- Compliance with the Managing Allegations / Person in Position of Trust (PiPoT) process including referral and liaison with the Local Authority Designated Officer (LADO) for safeguarding children.
- Strong assurance that the safer sleep assessment tool is being completed with parents/carers at least once with 100% recorded in notes audited, which is consistent with the previous audit.

Service risks and Priorities include:

- Continued work across the system to reduce time spent in acute hospitals for children who require ongoing local authority placements.
- The continued work across the system to reduce time spent in hospital awaiting inpatient mental health care for children and young people and adults.
- A continued focus on supporting patients with a mental health difficulty, collaborating risk plans and reducing risk behaviours particularly when awaiting a mental health bed.
- Delivery of the key objectives of the Safeguarding workstream of the Single Improvement Plan as follows:
    - Environmental improvements to increase the number of calm spaces.

    - Develop data reporting for physical restraint and rapid tranquilisation to show reasons for use and occurrences for people with protected characteristics.
    - Increased oversight of restraint incidents by Divisions through reporting into Divisional Improvement Forums.
    - Delivery of the 32 recommendations following the external expert review of security services conducted in 2024.
    - Increased use and visibility of the Reasonable Adjustments Needs tab within the patients' electronic records.
    - Training for key areas on mental health care in acute hospitals.
    - Deep dive reviews using Patient Safety Incident Response Framework (PSIRF) principles for the areas with the highest levels of physical restraint.
    - Compliance with rapid tranquilisation safety standards.
    - Refreshed approach to Enhanced Therapeutic Observation and Care (ETOC) and participation in the NHS England ETOC collaborative
- Collection and utilisation of patient feedback within vulnerable groups.
- The continued need to ensure staff knowledge and understanding of the Mental Capacity Act (MCA)/Deprivation of Liberties (DoLS) process.
- Reduction in health inequalities for vulnerable groups.
- Ensuring Trauma Informed Care through increasing staff training to achieve full compliance with the Children's Safeguarding Assurance Partnership Pan – Lancashire Section 11 audit.
- Focus on increasing compliance with the use of the safeguarding checklist for 16 and 17yrs old admitted to adult wards.
- Continue to maintain strong oversight of Managing Allegations/ PiPoT cases and provide expert advice and training.
- Strengthen the delivery of safeguarding supervision, with greater focus on adult services in line with PSIRF incidents and within high acuity areas i.e. ED.
- Maintain a drive into ensuring reasonable adjustments for our children, young people and adults, ensuring reasonable adjustment needs are considered when frequent attendances are occurring and improve the reporting on compliance with following the plans for these patients.
- Embed the newly developed neglect tool in partnership with other agencies. The neglect tool will be embedded and launched throughout the coming year.
- Highlighting and working to improve our response to children at risk of sexual harm has been a large part of our work in 2024/2025, this will continue for the forthcoming year.
- Review the offer of Learning Disability and Autism training in line with the Oliver McGowan draft code of practice on statutory learning disabilities and autism training
- To develop a Special Educational Needs or Disabilities (SEND) Priority Action Plan (PAP) in line with the Lancashire & South Cumbria (L&SC) PAP. Attend the newly established L&SC systems SEND Improvement Board and Operations Board, working with key colleagues in the Children's Division to drive improvements.

Recommendation

The Board of Directors are asked to receive the report noting the Safety and Quality committee have confirmed they are assured of the safeguarding arrangements in place.

The full report is included in the ancillary pack.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			

9.4 *MATERNITY AND NEONATAL SERVICES

Other | S Morrison | 10.20am

* Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack
Item for Assurance

REFERENCES

Only PDFs are attached

9.4 - Maternity and Neonatal Safety Report - July 2025 for August Board Executive summary.pdf

Board of Directors

Maternity and Neonatal Services Safety Report					
Report to:	Board of Directors	**Date:**	7 August 2025		
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert		
Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide the Board of Directors with an update report in relation to workforce, staffing and safety, quality, assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) for the year 7 reporting period. (1 December 2024 to 30 November 2025). The report has been scrutinised by the Safety and Quality committee on 25 July 2025 who agreed the following recommendations.

I. Endorse the Maternity and Neonatal Service report.
II. Receive the CNST Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans for oversight and assurance.
III. Formally receive the letter from NHS England and scrutinise the response to the instructions contained within.
IV. Monitor the resolution to the increase in Caesarean Section activity.
V. Confirm it is assured of the oversight and monitoring mechanisms within maternity services

The report covers the period up to the end of June 2025. To date the service remains on track to deliver 9/10 MIS standards, with one declared at risk due to changes to the requirements for the Maternity and Neonatal Voice Partnership lead responsibilities. Additional CNST supplementary information to support oversight is detailed in appendix 1.

The perinatal quality surveillance dashboard (PQSD) is included in Appendix 2. The model provides a structure for reporting and escalating quality and safety risks that are emerging or evident. Areas of increased pressure are demonstrated in the red flag reporting in month relate to delay in being assessed by an obstetrician, within 30 minutes in maternity triage and this continues to be the highest reporting category. Delay in induction of labour at various touch points continues to be one of the frequently reporting categories. Updates relating to the improvement work for induction of labour is included in the body of the report.

In the month of June 2025, there has been an increase in the occasions where the escalation policy has been utilised in response to acuity and staffing levels to maintain safety of the maternity service. 2 diverts were enacted, once for a duration of 8 hours and the second for 4 hours in total. This affected a total of 8 women. All women were transferred for triage assessment and have since returned to continue care within the service. No harm has been associated with transfer and letters to apologise will be sent to affected families.

The vacancy for registered midwives is currently 17.85 WTE and the next round of recruitment is planned for the August 2025. At this time is expected that all vacancies will be filled. The fill rates for Registered Midwives in June 2025 (RM) (94%-day, 91% night) and Maternity Support Workers (MSW) (80% day and 93% night). The lower-than-expected fill rates for maternity support workers are attributed to long term sickness absence. Close monitoring of the establishment is ongoing, and the service is taking interim actions to improve fill over the next 3 months, whilst awaiting new starters.

On 23 June 2025, NHS England wrote to NHS providers confirming a rapid independent national investigation into maternity and neonatal services. (Appendix 4) NHS England announced that a taskforce would be convened to agree immediate actions for improvement in care. The review will focus on up to 10 NHS trusts where specific concerns have been raised. As yet the affected maternity services have not been confirmed.

The instruction for Boards was to take action in the following areas. LTHTR response is detailed in italics after each instruction.

- **Be rigorous in tackling poor behaviour where it exists; where there are examples of poor team cultures and behaviours these need addressing without delay**

  Response*: A culture review and improvement plan commenced with the SCORE survey in 2024 as part of involvement n the national maternity neonatal development programme and has continued with an in-depth review of culture that will enable a deep understanding of areas that require focus. Whilst the deeper work is underway the service has continued to deliver interventions aimed at creating a safe and effective culture within the service.*

- **Listen directly to families that have experienced harm at the point when concerns are raised or identified; it is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed**

  Response*: The service meets the requirements outlined in the CNST Maternity Improvement Standard 1 which requires that at least 95% of all perinatal mortality reviews include parents perspectives and feedback.. The bereavement midwives act as a key liaison between the clinical team and bereaved families, supporting parents to share their experiences and concerns. Family liaison and follow up care is provided through specialty services as required.*

  The MNVP chair is actively involved in providing feedback from a wide range of women and families experiences the services. Where harm has occurred, duty of candour is applied, and compliance is monitored.

  As part of MIS safety action 8 service training is aligned to the Core Competency Framework v2 (CCFv2) developed by NHS England which integrates service user feedback as a minimum standard for training in maternity and neonatal services 1. It is used to inform training content based on real experiences, shape learning from incidents, both positive and adverse, tailor training to local needs, ensuring relevance and responsiveness and includes service users in training days, sharing their stories to enhance empathy and understanding

  There is a speak up champion within the women's and children division, the refreshed speak up arrangements for the organisation have advertised for further expressions of interest.

  The maternity and neonatal safety Board safety champions undertake frequent walk around alone in the services to ensure colleagues have the opportunity speak up. This feedback is included in you said we did format. There is evidence within the service where attitude concerns are identified performance plans are enacted. There is evidence that learners' experiences are not consistently positive, and this is

leading to further focus as part of the culture improvement work. Recent safety champion walkrounds have identified good practice in relation to the planned increase in core delivery suite posts, involvement in after action reviews, debrief led by neonatal consultants, access to TRIM trained practitioners and Professional Midwifery advocates. Walkrounds have also identified the opportunity need to strengthen the approach to understanding how learning takes place following incidents, communication of improvements and progress within the service. These are being progressed within the service.

- **Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your maternity and neonatal voice partnership, and local women, and families**

  ***Response**: The MNVP chair is actively working with the service providing a variety of sources of feedback. Appendix 6 outlines additional sources of intelligence.*

- **Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both**

  ***Response**: The monthly maternity and neonatal report is scrutinised by the safety and quality committee and presented to Board for assurance as part of a regular cycle of business. The outcome dashboard that underpins the report is presented using SPC charts and analysis of this is triangulated within the report.*

- **Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions; a new anti-discrimination programme from August will support our leadership teams to improve culture and practice**

  ***Response**: The Race and Health Observatory improvement work on reducing postpartum haemorrhage has now led to involvement in a national programme of work aimed at further reducing health inequalities. The health improvement plan of the organisation addressing the systematic approach of the organisation. The service continues to provide enhance midwifery services to groups more likely to experience health inequalities. The trust is currently preparing to become accredited as an antiracist organisation.*

  Accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

  ***Response**: The plan to review how the continuity teams can incorporate this will be considered as the recruitment to Birthrate plus is enacted in October 2025 and staffing stabilises further within the service. Involvement in national work will enable an approach to data that allows a greater understanding of those using services and will form the basis of preparation work ahead of staffing levels stabilising. This programme of work remains a clear aspiration of the service.*

Based on the instruction within the letter and to support the Board to discharge their responsibilities, this maternity and neonatal report, will continue to be scheduled monthly on the cycle of business for Safety and Quality committee. It is proposed the Board of Directors will receive biannual presentations by a member of the perinatal leadership team and receive the Safety and Quality reports for information as part of each Board of Directors.

***The full report is in the ancillary pack.**

RECOMMENDATIONS

The Board of Directors are asked to:

i. Receive the report for information, noting the scrutiny that has taken place at safety and quality committee.
ii. Note the update to the cycle of business reflecting the reporting arrangements.

Appendices

1. Clinical negligence scheme for trust information pack CNST year 7
2. Perinatal Quality Surveillance Supplementary Pack
3. Red Flags Data
4. Secretary of State Letter
5. Induction of labour Driver Diagram and trend data analysis.
6. Perinatal Safety Surveillance

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place to Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For the Future	☒

Previous consideration

None

9.5 WINTER PLANNING ? LESSON LEARNT AND PLANNING 25/26

Other | K Foster-Greenwood | 10.30am

Item for Assurance

REFERENCES

Only PDFs are attached

9.5 - Winter Planning Paper 2425 .pdf

Board of Directors

Winter Surge Planning Report 2024/25							
Report to:	Board of Directors			**Date:**	7 August 2025		
Report of:	Chief Operating Officer			**Prepared by:**	K Foster-Greenwood		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☒	**For noting**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

Executive Summary

Winter planning processes and data analysis identified a projected increased demand over the winter period which anticipated a bed deficit of between 41 and 113 beds (variation month on month based on demand trend) and a potential corresponding negative impact of Emergency Department (ED) performance against the 4 hour standard of between 0.5%-3.5% if unmitigated.

Plans were established to mitigate the anticipated surge in demand and associated performance risk. This paper will provide a summary of the actual activity levels over the 24/25 winter period and a specific focus over the Christmas and New Year holidays, provide a summary of delivery of schemes and impact and highlight areas of learning which will be adopted within the Winter Planning process for 25/26.

A review of data pertaining to Winter of 24/25 (Oct to March) compared to the previous year showed that:

- **ED Attendances**: Oct 24-Mar 25 saw 92,903 ED and UCC attendances. This is a 5% drop in attendances compared to the same period in 2023/24. Performance against the 4 hour target over the winter period averaged at 69.3%, (an improved position versus 23/24 by 1.7%) which was below the required target of 76-78%, however was higher than the unmitigated projections.
- **Ambulance Arrivals**: During Oct 24-Mar 25 there were 14,916 ambulance arrivals compared to 15,543 during the previous year, a drop of 627 (4%) ambulance arrivals. Handover delays of over 60 minutes increased by over 600 in Oct-Mar 2024/25 compared to 2023/24. The proportion of patient handovers within 60 minutes dropped from 89.6% to 84.1% during the same periods.
- **Bed Demand**: Bed occupancy exceeded the anticipated 95% in 4 of the 6 months and was on average 95.4% throughout the winter period. Numbers of boarding ranged between an average per month of 17 (Nov & Dec 24) to a high of 38 in Jan 25. This is an improvement compared to the previous year – average per month of 23 (Nov & Dec 23) with a high of 40 in Feb 24.

- **Days Kept Away from Home or No Medical Criteria to Reside (NMC2R) Patients**: On average 91 patients were recorded as NMC2R on a day basis during Oct-Mar 2024/25 compared to 82 during the same period the previous year.

A review of data pertaining to the festive period in 24/25 compared to the previous year showed that:

- **ED Attendances**: During the Christmas and New Year period, ED and UCC attendances were 6% lower than the previous year. However, the total time spent within the Emergency Department increased, with a 1.6% rise in the number of people spending 12 hours or more in the ED.
- **Ambulance Arrivals**: There was a 6% reduction in the number of ambulance arrivals during the festive period.
- **Bed Demand**: Bed occupancy pressures increased, but the number of patients being cared for in non-core bed areas (boarded patients) was lower than the previous year. The average daily boarded patients reduced from 20 in 23/24 to 18 in 24/25.
- **No Medical Criteria to Reside (NMC2R) Patients**: The overall number of NMC2R patients reduced compared to the same period in 23/24, but there was a marked increase towards the end of 2024 and into January 2025.

Therefore overall findings were:

- There were less EC & UCC attendances over the winter period 24/25
- 4 hour performance was below target but higher than the unmitigated projections suggesting partial mitigation via winter schemes
- There were less ambulances than during the winter period last year but performance was lower than last year re ambulance handover
- There was less boarding than the same period last year
- Days Kept Away from Home levels were higher than last year.

The key learnings from the winter schemes include several important insights:

Earlier Winter Planning: It was identified that winter planning needs to start earlier. For the 2025/26 winter period, planning has commenced in June 2025.

Earlier Scheme Identification, Approval, and Mobilisation: To fully realize the benefits of the schemes, it is necessary to identify, approve, and mobilize them earlier.

Efficacy of Additional Beds: While the continued need to 'board' patients is unacceptable and needs to be eradicated, the absence of additional beds did not increase the number of boarded patients versus 23/24. However, it contributed to the extended ED length of stay (LOS). Further consideration will be given to the efficacy of additional beds in future winter plans.

It is recommended that:

I. The Board of Directors note the contents of the report and the continued analysis of the impact of surges in demands and mitigating actions over the winter period of 24/25.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☐
Previous consideration			
N/A			

Background

Lancashire Teaching Hospitals NHS Foundation Trust (LTH) undertook its winter surge planning internally and with Integrated Care Board (ICB) partners to develop options to ensure the effective management of surge demand over the winter months.

The Integrated Care System (ICS) worked with partners to identify schemes which have been funded via the Urgent and Emergency Care (UEC) capacity investment funds. Schemes focus in several key areas:

- Create additional capacity (e.g alternatives to emergency departments, support timely discharge)
- Improve urgent and emergency care performance
- Improve patient experience and quality of care
- Deliver financial benefits

Additionally internal LTH schemes were identified and mobilised to support winter demand. Schemes were focused on:

1) ED attendance avoidance
2) ED Breach/over-crowding avoidance
3) Length of Stay (LOS) reduction
4) Admission avoidance

Surge Impact – Winter 24/25

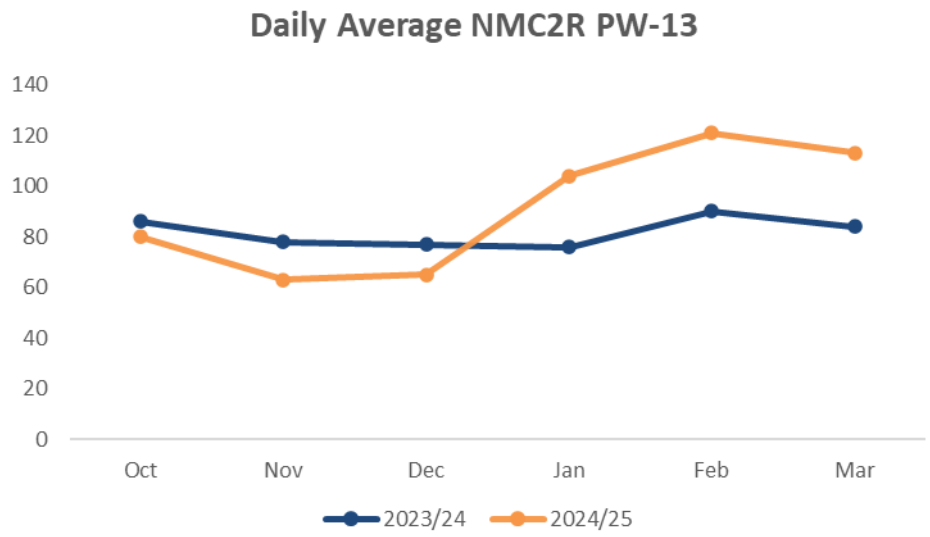
ED Attendances
Data pertaining to the 6 month winter period (Oct-Mar) has been collated and shows that ED and UCC attendances were 5% lower than the previous year. Similarly 4 hour breaches were recorded to be 11% lower than the same period in 23/24 with on average 16 less breaches per day during the period. Overall 4 hour performance improved by 1.7% during the 2024/25 winter period compared with the same period in 23/24. On average attendances were 22 per day lower than in the same period in 2023/24.

The total time spent within the Emergency Department was lower than that seen in 23/24 with a 2.6% decrease in the number of people spending 12 hours or more in the Emergency Department.

Ambulance Arrivals
The winter period in 24/25 saw a 4% reduction in the number of ambulance arrivals compared to 23/24.

Bed Demand
Pressures re bed occupancy increased over the winter period with the number of patients being cared for in non core bed areas (boarded patients) lower than that seen in 23/24 however this remains a key concern. The average daily boarded patients over the winter period in 23/24 was 29, this reduced to 25 in 24/25.

The overall number of Days Kept Away from Home or ‘No Medical Criteria to Reside’ patients increased in 24/25 versus the same period in 23/24. The data below shows how there was a marked increase in the final quarter of 2024/25.



Surge Impact – Xmas and New Year

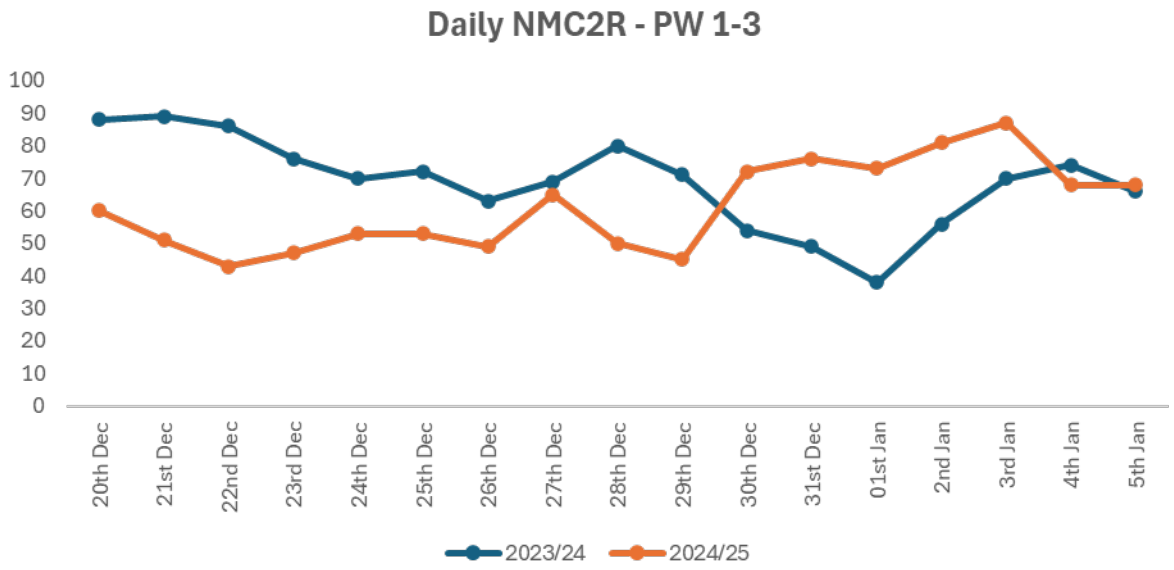
ED Attendances
Data pertaining to the key Xmas and New Year period has been collated and shows that ED and UCC attendances were 6% lower than the previous year. Similarly 4 hour breaches were recorded to be 4% lower than the Xmas and New Year period 23/24 however as a result of the activity reduction, overall 4 hour performance was 0.36% lower than the same period in 23/24. Attendance patterns were typically very similar over the bank holidays to 23/24 with the exception of New Years Eve which saw 104 less ED attendances than in 23/24.

The total time spent within the Emergency Department was in excess of that seen in 23/24 with a 1.6% increase in the number of people spending 12 hours or more in the Emergency Department.

Ambulance Arrivals
The festive period in 24/25 saw a 6% reduction in the number of ambulance arrivals.

Bed Demand
Pressures re bed occupancy increased over the festive period with the number of patients being cared for in non core bed areas (boarded patients) lower than that seen in 23/24 however this remains a key concern. The average daily boarded patients over the festive period in 23/24 was 20, this reduced to 18 in 24/25.

The overall number of 'No Medical Criteria to Reside' patients also reduced in 24/25 versus the same period in 23/24 however the data below shows how there was a marked increase towards the end of 2024 and into Jan 2025.



Winter Schemes

Winter schemes were designed and proposed by clinical and operational teams and are described below with details of the intended impact and outcomes. Schemes were 'commissioned' with an understanding that if they did not deliver the intended outcome or could not be mobilised they would be ceased and where possible the winter funds would be re-invested.

Scheme	Aim	Impact	Outcome
Extended SDEC capacity	To extend the operational hours of the SDEC service to support a reduction in ED overcrowding	Evening resource has supported 38.1% patients via SDEC – This is an increase from 33.4% in the same period in 23/24.	This scheme required the use of additional adhoc staffing. SDEC data shows a baseline level of 33% Apr 24-Sept 24. Over the winter months there was increases seen in all months with a significant increase noted in Feb 24 showing performance above the 40% target thereafter.
Extended weekend AMU Medical Staffing	To expedite senior medical assessment and review at weekends to facilitate earlier discharge	23/24 winter weekend discharge rate baseline for RPH AMU was 27 for December to February 2023/2024 December 2023 – 15 January 2024 – 8 February 2024 - 4	Not all shifts covered. However, there was a noticeable increase at RPH AMU against last year's baseline for weekends as follows; December 2024 – 26 January 2025 – 23 February 2025 – 25 In addition, the medics provided acute review to support safety on wards as required.

Acute Cons ED – Dr@Door	To provide additional medical staff to pilot a Dr@Door model which would stream patients to the most appropriate services at an earlier opportunity	Dr@Door pilots and desk top peer review have failed to identify alternative commissioned pathways to support deflections.	The scheme was de-commissioned mid Feb 25.
Additional night upper grade medical staff in Paediatrics	To support increases in demand for Paediatric services	Apr-Sept 24/5 = 72.9% Oct-Mar 24/5 = 64.6% Oct–Mar 23/4 = 60.4%	A reduction in wait times for PAU by 7.4% compared with same period the previous year.
Paediatric cold week capacity	To provide additional capacity to ensure timely assessment of children		Reduction of incidents reported by 54.5% compared with same period in previous year. Improvement in 14-hour Consultant reviews. Increase in new outpatient appointments undertaken. Reduction of £225k on agency and bank spend. Improvement in trainee feedback.
Expanded discharge lounge capacity	To provide capacity to support a 'pull' model and facilitate earlier discharge	NEL Discharges from RPH Discharge Lounge Oct-Mar 24/5 = 3609 Oct-Mar 23/4 = 3336 Increase of 7.6% in 24/5	Numbers of transfers have been lower than anticipated due to the Discharge lounge being 'bedded' and sickness impacting staffing.
Additional winter bed capacity	To provide additional bed capacity for 3 months over the Winter period	NA	Due to high levels of sickness and absence related to Respiratory and GI conditions, it was not possible to open additional bed capacity.

Overall there was a strong evidence regarding the effectiveness of an expanded SDEC offer however the site pressures often compromised the use of this area. This is something which has been considered and changes have been made to the Trusts escalation policy to protect this space for its intended purpose to protect the optimal flow out of the Emergency Department.

Increases in the discharge lounge utilisation were noted however the lack of ring fencing of the area precluded full realisation of the scheme benefits.

The Weekend AMU scheme showed positive outcomes however struggled to fully deliver the optimal benefits due to difficulties in filling posts. Early mobilisation for subsequent years may mitigate this gap.

Paediatric schemes noted reductions in waiting times, improvement in Consultant review within 14 hours, reduced incidents, reduced high cost pay spend and improved staff morale.

The ED Dr@Door and additional bed schemes were not successful or not possible to mobilise and therefore we decommissioned.

Learning/Reflections

On reflection there are a number of learning opportunities identified in relation to winter planning in 24/25 including:

1) Earlier Winter Planning is required. It is proposed that Winter Planning for 25/26 will commence in June 25.
2) Earlier scheme identification, approval and mobilisation is required to allow the full benefit of schemes to be realised.
3) Whilst the continued need to 'board' is unacceptable and needs to be eradicated, the absence of additional beds did not increase the number of boarded patients. It will however have contributed to the extended ED LOS – therefore it is proposed that further consideration is given to the efficacy of additional beds being mobilised in future winter plans.
4) Protecting facilities from being used as additional bed spaces needs to be considered for future surge planning.
5)

Recommendations

It is recommended that:

I. The committee note the contents of the report and monitors the winter planning progress for 25/26.

10. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)

10.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | A Leather | 10.40am

Item for Assurance

REFERENCES

Only PDFs are attached

10.1 - WFC Chair's Report - 8 July 2025.pdf

Chair's Report to Board		
Chair: Adrian Leather	**Workforce Committee**	
Date(s): 8 July 2025	**Agenda attached for information**	✓

Strategic Risks	trend	Items Recommended for approval
People: Be a Great Place to Work – current score 16	→	**Guardian of Safe Working Annual Report** **Social Value Strategy**

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- There are ongoing challenges with the capacity of the workforce information team, impacting the ability to provide detailed and timely data. Efforts were being made to address this through potential recruitment and collaboration with external partners. The Board should be alerted to the critical need for resolution in this area to support effective decision-making.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee discussed the consolidation of risks related to gaps in medical cover and the need for a detailed understanding of these risks. A report on fragile services was expected in September. The Board should be advised of the ongoing efforts to address these risks and the importance of timely recruitment and retention strategies.
- A new policy was being developed to address non-compliance with mandatory training, including potential disciplinary actions and restrictions on additional study leave and bank shifts. The Committee supported the implementation of this policy and would monitor its impact on compliance rates while emphasising the need to reduce tolerance for non-compliance and ensure clear expectations are set across the organisation.

ASSURE

Assurance received;
Matters of positive note.

- Significant progress had been made in addressing long-term sickness absence, with focused efforts on mental health and the introduction of new resources and initiatives and the Committee were assured of the ongoing efforts and the expected positive impact on sickness absence rates in the coming quarters.
- Positive progress had been made in promoting a positive organisational culture, with a focus on sexual safety, civility, and compassion. The health and wellbeing strategy aligned with broader organisational goals. The Board should be assured of the comprehensive approach being taken and the expected benefits for staff engagement and retention.

Workforce Committee

8 July 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	A Leather
2.	Apologies for absence	1.01pm	Verbal	Information	A Leather
3.	Declaration of interests	1.02pm	Verbal	Information	A Leather
4.	Minutes of the previous meeting held on 13 May 2025.	1.03pm	✓	Decision	A Leather
5.	Matters arising and action log	1.05pm	✓	Decision	A Leather
6.	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Assurance	K Downey
7.2	Staff Sickness Deep Dive and Action Plan	1.25pm	✓	Assurance	R O'Brien
7.3	Addressing Mandatory Training Compliance	1.35pm	✓	Decision	N Pease
8. TO ATTRACT, RECRUIT AND RESOURCE					
8.1	Annual Job Planning Report	1.45pm	✓	Assurance	K Downey
9. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
9.1	Annual Workforce Advice Update Report	1.55pm	✓	Assurance	R O'Brien
9.2	Social Value Strategy Update	2.05pm	✓	Assurance	L Graham
10. TO BE INCLUSIVE AND SUPPORTIVE					
10.1	Annual Health and Well-being Strategy Report	2.10pm	✓	Assurance	R O'Brien
11. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					

№	Item	Time	Encl.	Purpose	Presenter
11.1	Annual Culture Strategy Report	2.20pm	✓	Assurance	L Graham
12.	GOVERNANCE AND COMPLIANCE				
12.1	Guardian of Safe Working Annual Report (inc. Jan-Mar Quarterly report)	2.30pm	✓	Decision	D Kendall
12.2	Strategic Risk Register Review	2.40pm	Verbal	Decision	A Leather
12.3	Items to alert, assure, advise to the board or items or referral to/from other committees	2.45pm	Verbal	Information	A Leather
12.4	Reflections on the meeting	2.50pm	Verbal	Assurance	A Leather
13.	ITEMS FOR INFORMATION				
13.1	Chairs' Reports from Feeder Groups/Workstreams a) Temporary Staffing Group b) Raising concerns		✓		
13.2	Date, time, and venue of next meeting: *9 September 2025, 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	A Leather

10.2 *GUARDIAN OF SAFE WORKING REPORT

Decision Item | N Pease | 10.50am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

10.2 - GOSW Annual Report 2024 for Board FINAL.pdf

Board of Directors

GUARDIAN OF SAFEWORKING ANNUAL REPORT 2024							
Report to:	Board of Directors			**Date:**	7 August 2025		
Report of:	Neil Pease			**Prepared by:**	D Kendall and Lisa Eccles		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide assurance (or otherwise) to the board with regards to safe staffing levels for resident doctors and clinical fellows who are employed on a mirrored resident doctor's contract, particularly in reference to vacancies and subsequent rota gaps. This report covers the period of January 1st 2024 to December 31st 2024 to provide a summary for the year

The following information has been reviewed in compiling this report:

- Exception reporting data
- Guardian of Safe working (GOSW) quarterly reports
- Resident doctor forum
- Vacant posts

Summary of Report

- There was a significant increase in exception reporting in 2024 to 670 reports (this was compared to 520 in 2023) and there were 34 immediate safety concerns (ISCs) (this is significantly more than the 16 ISCs in 2023).
- Large numbers of exceptions were particularly seen in the following specialties:
  - Chorley Medicine (53 FY1),
  - Surgical Specialties at RPH (193 – all grades),
  - Oncology (71 – all grades),
  - Urology (JCF –48),
  - Vascular (64 – all grades),
  - Medicine RPH (48 all grades)
  - T&O (44 all grades).
- Most exception reports are submitted by FY1 doctors (60%), particularly in the first 3-4 months after they start in August. The main reasons for the Exceptions were extra hours worked and lack of senior support.

- High numbers of exception reports and ISCs (mainly relating to lack of senior supervision and extra hours worked) suggest that medical staffing levels in CDH Acute Medicine, Vascular Surgery and RPH Surgical Specialties should be urgently reviewed. The potential risks to staff welfare, morale and patient safety are highlighted by this report.

- The issues identified by the exception reports have been raised, by the GOSW, with the relevant departments and discussed at the Medical Workforce Committees throughout the year.

- There remain some challenges in filling non-training middle grade vacancies and this impacts upon resident doctor rotas, affecting the supervision of junior grades and increasing the workload for the doctors who are left to fill the gaps. The actions taken to address these vacancies and rota gaps are detailed within the report.

- There were 3 Resident doctor forums held in 2024 (29th February 6th June and 14th November).

Immediate Safety Concerns

When submitting an exception report doctors can highlight the report as an Immediate Safety Concern (ISC). ISC are escalated to the GOSW for immediate review.

There were 34 exceptions submitted as immediate safety concerns during 2024, more than double the 16 ISCs in 2023. The 2 main themes identified included lack of senior support and inadequate medical staffing levels, leading to concerns about patient safety. We encourage doctors to submit Datix for all the ISCs, so that any specific patient safety concerns can be investigated through the appropriate governance routes. The GOSW also sends all the ISCs to the relevant management teams for investigation and action.

Areas of Concern and Actions Taken (work schedule reviews):

Chorley Medicine

There were high numbers of exception reports from doctors working within Medicine at Chorley as well as 15 ISCs and concerns expressed in various forums (RDF and Foundation Forum) by FY1s and other Resident Doctors. This concerns related to the lack of senior supervision associated with the lack of senior staff staffing support on the wards and long hours of work. These issues are persistent and have been raised consistently over the past 6 years.

If senior members of a particular team are on leave or off after nights or weekends, this leaves the junior team members without senior support. Some of the ISCs have arisen in Chorley due to both the consultant and registrar being off at the same time, often leaving the FY1 alone. Last minute sickness has also contributed to the problems. There is very little flexibility for senior cover when Consultant and/or middle grades are off at short notice, and it is very difficult to recruit suitable locum candidates. There is comparatively less middle grade doctors at Chorley compared to Preston and less Resident doctors overall. The teams are also smaller than the RPH teams and so cross-cover between teams is far more difficult.

Furthermore, there are general team support, cultural and inter-team dynamic issues that have become evident from some of the exception reports comments. The DME, the Divisional Medical Director for Medicine and the Deputy Director of Workforce and OD have been working with the medical teams and Consultants in Chorley to address these concerns and this work continues. There is also a re-organisation of the wards taking place which has helped to alleviate some of the cross-cover issues.

Surgical Specialties RPH

The largest category of exceptions is in the RPH surgical specialties (all grades) and this trend started in the later part of 2021 and continued through 2022, 2023 and 2024. The high numbers of exception reports and all the ISCs have been reported to the surgical management team.

The issues have also been discussed and reviewed several times in the Divisional Workforce and Wellbeing Committee meetings. A combination of inadequate number of juniors compounded by sickness, patient acuity, and an increased number of referrals to the surgical departments are the driving force for the issues.

The division struggles to even employ locums or use the medical bank to provide cover when needed. It is busy and people are not very keen to do the extra work even if they are offered good rates of pay. This is compounded by continued issues with funding and budget, preventing progress to improve staffing levels. The H@N team is providing more cover on the surgical wards, but this can be variable.

Vascular Surgery

High numbers of exception reports and 4 ISCs have been submitted in Vascular Surgery in 2024. A meeting was held in May 2024 with the vascular department management team, CD, GOSW and the DME to discuss the various safety concerns that have been raised by the Resident doctors, with regards to the staffing of the vascular ward and how it was affecting patient care. Concerns were also raised at the February Resident Doctor Forum and in a focus, group held by the Education team (March 2024). One of the solutions discussed was for the H@N team to start accepting the calls from the surgical wards. An action plan to improve staffing was developed.

Vacancies within the Trust

Rotas are often made up of both resident doctors and locally employed doctors (Clinical Fellows).

Vacant posts are monitored monthly and particularly following each rotation. The trust has seen a decrease in trust vacant posts in 2024 but an increase in deanery gaps (FY2 and ST1-2). Posts filled by Less than full time resident doctors are not reported as a gap but the increase in LTFT does mean some posts have not been filled by a full-time therefore leaving some gaps on the rota. The trust has approx. 70 LTFT doctors on placement within the Trust. Vacant posts on rotas are also confounded by resident doctors who are off sick/on-long term sick and on maternity leave.

Resident Doctor Forum (JDF)

There were 3 Resident doctor forums held in 2024 (29th February 6th June and 14th November). During these forums the GOSW quarterly reports were reviewed, and various concerns were discussed, relating to some of the rotas and working conditions.

One of the main issues discussed in the November meeting was the use of the RPH doctors mess by the Acute medical team for their work including clerking patients etc. The discussion identified that there was not enough space for the doctors to do their work in the Emergency Department, and they felt the only option was to use the mess. This issue has also been raised at other forums, including JLNC, and actions are being taken by the Trust to find an alternative working space for the team.

It is recommended that the Board of Directors:

(i) Discuss areas of risk identified, particularly with reference to medical staffing provision in Chorley Acute Medicine, Vascular Surgery and the RPH surgical specialties (with reference to high numbers of exception reports and ISCs in these specialties).

The full report can be found in the ancillary pack

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☐	Great Place to Work	☒
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For the Future	☐

Previous consideration

Workforce Committee – July 2025

10.3 *SOCIAL VALUE STRATEGY

Decision Item | N Pease | 10.55am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

10.3 - Social Value Strategy .pdf

Board of Directors' Report

Social Value Strategy			
Report to:	Board of Directors	**Date:**	7 August 2025
Report of:	Chief People Officer	**Prepared by:**	L Graham
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to share the draft Social Value Strategy with the Workforce Committee for assurance and oversight.

The draft Social Value Strategy sets out our vision which is to 'Improve the lives of our communities and colleagues through our role as an anchor institution'. The key principles underpinning this vision statement is that all aspects of our work as an NHS organisation and employer should contribute towards the social value impact we make. The Social Value Strategy is integrated in the 5 corporate objectives of the organisation. This strategy is not designed to replace or supersede other core strategic aims of work. Its focus is on creating a framework which underpins and emphasises the programmes of work which acknowledge the leadership role we have in our community as an anchor institution and deliver tangible social value. To achieve the vision, the following strategic aims are proposed:

- Creating careers and opportunities by being a local employer of choice
- Leveraging our contracting, estate and sustainable practices to deliver local benefits and social value
- Connecting community and partnerships

The strategy describes the social value delivery framework which is designed to provide a consistent approach to embedding social value across the organisation, through informing colleagues of their role and how all parts of the organisation can contribute to fulfilling our role as an anchor institution. Maximising the social value impact of the actions we take across all strategic programmes of work through to proactively seeking to measure the impact we make in creating social value.

The strategy is currently being consulted upon with key subject matter experts and service leads invited to share views and feedback. The sections which require review and amendments are highlighted in red. Once consultation has been completed a final version will be developed for publication.
The full report is in the ancillary pack.

It is now recommended that the Board of Directors approve the Social Value Strategy.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	□	Consistently Deliver Excellent Care	□
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	□	Great Place To Work	□
To drive health innovation through world class education, teaching and research	□	Deliver Value for Money	□
		Fit For The Future	□
Previous consideration			
Not applicable			

10.4 EDUCATION, TRAINING AND RESEARCH COMMITTEE CHAIR'S REPORT

Other S Crean 11.00am

Item for Assurance

REFERENCES

Only PDFs are attached

10.4 - Chair's report - Education Training and Research Committee 10 June 2025.pdf

Chair's Report to Board		
Chair: Prof StJohn Crean	Education Training and Research Committee	
Date(s): 10 June 2025	Agendas attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
People and Partnership	→ 12	**None.**

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- There are ongoing challenges with achieving compliance in mandatory training, particularly among medical and dental staff. Specific metrics such as immediate life support, paediatric immediate life support, and newborn immediate life support had been areas of concern, although recent improvements had been noted.
- There are persistent issues with the suboptimal experience of resident doctors, where escalation and handover processes need improvement.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Collaboration with universities and the development of joint posts together with increased grant funding were critical steps in the journey towards achieving University Hospital status.

ASSURE

Assurance received; Matters of positive note.

- The Trust had made significant strides in its commercial research portfolio, including securing a partnership with BioNTech and achieving first UK recruitments in trials. This progress supported the Trust's sustainability and research capabilities.
- The Trust had achieved compliance in 30 out of 33 core skills training metrics, with recent improvements in resuscitation training compliance. This demonstrated a strong commitment to meeting training requirements.

Education, Training and Research Committee

10 June 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	S Crean
2.	Apologies for absence	1.01pm	Verbal	Information	S Crean
3.	Declaration of interests	1.02pm	Verbal	Information	S Crean
4.	Minutes of the previous meeting held on 8 April 2025	1.03pm	✓	Decision	S Crean
5.	Matters arising and action log	1.05pm	✓	Decision	S Crean
6	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7.	PERFORMANCE				
7.1	Education contracts review: Medicine	1.15pm	Pres	Assurance	Mark Brady, Michael Brown, Nicola Fallon, Amy Booth
7.2	Education contracts review: DCS	1.35pm	Pres	Assurance	Russell Dineley, Deborah O'Mahoney, Parag Desai
7.3	Education contracts review: Surgery	1.55pm	Pres	Assurance	Lisa Elliott, Steve Canty, Kate Hudson
7.4	Core Skills Training Report	2.15pm	✓	Assurance	L O'Brien
8.	STRATEGY AND PLANNING				
8.1	Research and Innovation Annual Report Strategy Update (interim review)	2.25pm	✓	Decision	P Brown
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic Risk Register Review	2.35pm	Verbal	Decision	S Crean
9.2	Items to alert, assure, advise to the board or items or referral to/from other committees	2.40pm	Verbal	Information	S Crean

№	Item	Time	Encl.	Purpose	Presenter
9.3	Reflections on the meeting		Verbal	Assurance	S Crean
10.	ITEMS FOR INFORMATION				
10.1	Feeder Groups – Chair's Reports a) Education Finance and Performance b) Education Governance and Risk c) Research and Innovation		✓		
10.2	Date, time, and venue of next meeting: *12 August 2025, 1pm, MS Teams*	2.45pm	Verbal	Information	S Crean

BREAK

11.10am

11. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)

11.1 INTEGRATED PERFORMANCE REPORT

Other | Executive Team | 11.25am

including Finance update and Single Improvement Plan
Item for assurance

REFERENCES

Only PDFs are attached

11.1 - Integrated Performance Report as at 30 June 2025.pdf

Board of Directors Report

Integrated Performance Report			
Report to:	Board of Directors	**Date:**	7th August 2025
Report of:	Executive Team	**Prepared by:**	Executive Directors
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of the report is to present the Integrated Performance report to the Board of Directors with the position up to June 2025, unless date otherwise stated.

The report provides the Single Improvement Plan, high level metrics, of which the outcomes have been scrutinised by each relevant committees of the Board. The outcome metrics are presented with a supporting summary, assurances provided and actions being taken to address the position where improvement is identified.

The delivery milestones of the single Improvement plan are monitored through the Finance and Performance committee. The reporting around this continues to be refined with a plan to include milestone assurances in future IPR reporting.

At the start of each priority section, a 3 A (Alert Advise and Assure) template is provided to guide the Board to areas of Alert Advise or Assure in line with the reporting approach adopted by the committees of the Board.

The Chief Operating Officer will present the IPR with Executive Director presentation for each of the priorities.

The Board of Directors is asked to receive the integrated performance report, note the monitoring of the Single Improvement Plan delivery milestones is undertaken through the Finance and Performance committee and confirm it is assured of the Single Improvement Plan outcome metrics.

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching, and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

August 2025 Trust Board meeting with performance to June 2025

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

SECTION	PAGE
Key to KPI Variation and Assurance icons	2
How to read Statistical Process Control charts (SPC)	3
SPC KPI Metric Grid	4
People	05 - 08
Patients	09 - 11
Productivity	12 - 15
Performance	16 - 19
Appendix 1 – Assurance Reports	20 - 39

Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Key to Metric SPC Chart and Variance and Assurance Icons

Assurance Icons – How likely are we to hit the set target in future?

- It's possible the target could be either passed or failed within the expected month to month variation of the measure
- The target will be consistently failed within expected variation unless the process is changed
- The target will be consistently passed within expected variation unless the process is changed

Variation Icons – Is the measure showing signs of change over time?

- No signs of change over time evident in recent data
- An example of concerning change is evident in the recent data
- An example of positive change is evident in the recent data

Report heading explanation

The Assurance Icon indicates whether the metric is failing or passing the target, or is inconsitently passing and

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

Metric Description	Assurance @ Mar-25	Variation to Latest Actual	Target: Concern	Target: Mar-25	Target: Latest Month Target	Latest Month Actual	Latest Month
Example Measure				100.00%	98.00%	95.00%	Jul-24

The name of the Metric

This shows whether there is a special or common cause variation of the metrics.

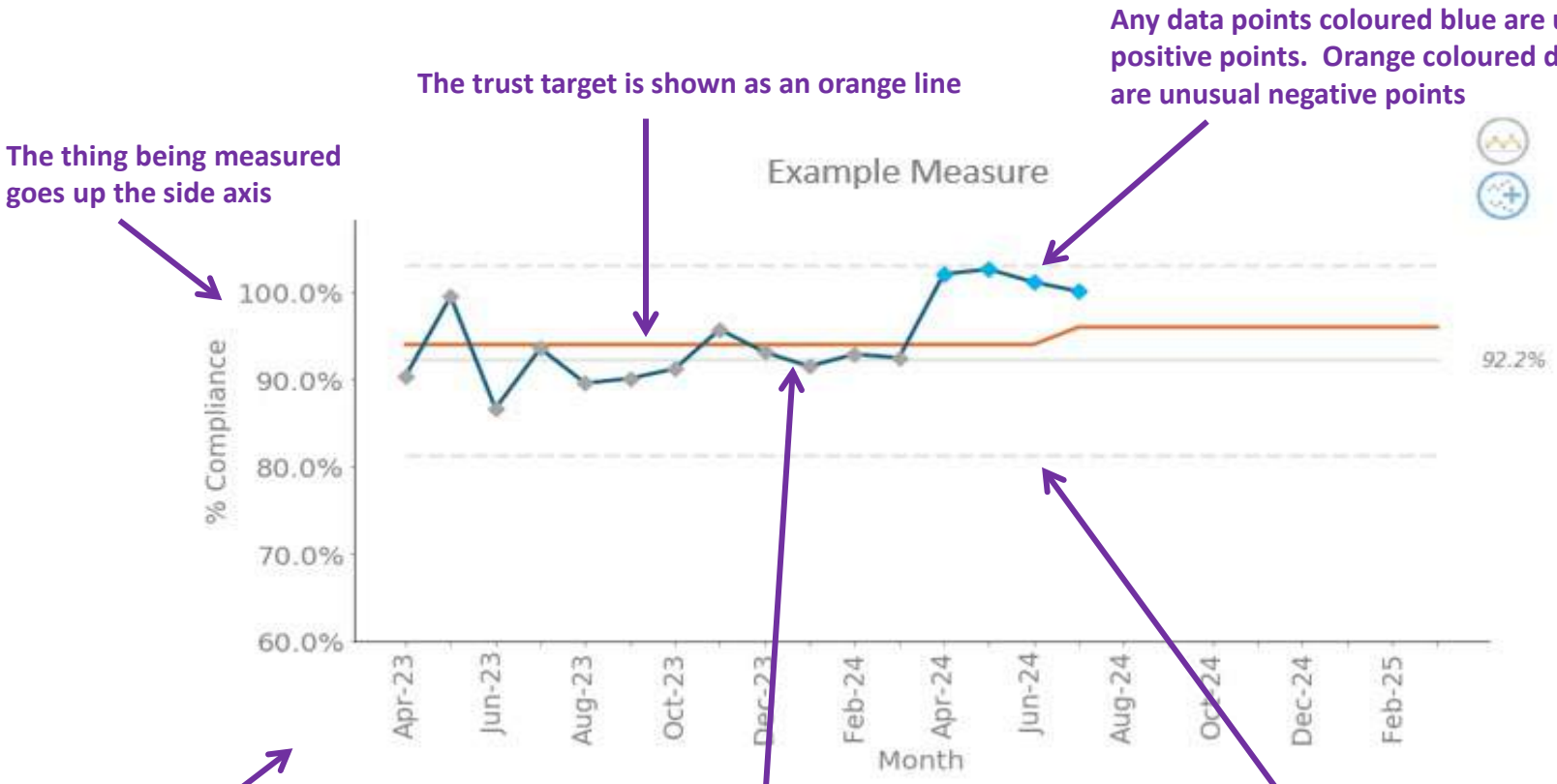
This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

Statistical process control (SPC) charts are a tool used to understand change over time and variation of a process or system. They are used commonly within healthcare to understand if improvement actions are impacting the data and to give assurance around set targets.



Rebasing is the recalculation of the mean and control limits when a statistically significant pattern indicating a sustained change is seen in the data - *not shown in this chart example*.

SPC KPI Metric Grid

Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Percentage of patients waiting less than 18 weeks - Cancer 62-day performance	- Vacancies (% FTE) - RTT - 52 week Waiters	- Staffing Fill Rate - Registered Nurse - STAR Accreditation all trust (Silver and Above)
Normal variation - no recent change	- Sickness Absence (%FTE) - Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Maximum wait of 12 hours as Total Time in Department - Bed occupancy to 90% - Number of boarded patients - Reduce not meeting criteria to reside - RTT - 65 Week Waiters - 31 Day Cancer Standard - Staffing Fill Rate - Maternity Support Worker	- Number of violence and aggression incidents toward staff - Turnover (%FTE) - Staffing Fill Rate - Health Care Assistant - Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - C. diff perf against national trajectory - no more than 199 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - Compliance with 60 minute ambulance turnaround time target	
Recent positive pattern in the data	- Percentage of patients that receive a diagnostic test within six weeks	- Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety	

Non SPC Metrics flagged as a concern

% of must do's from QIP 2023/24 assessed as Green (i.e. delivered)

% of should do's from QIP 2023/24 assessed as Green (i.e. delivered)

I&E - Plan V Actual variance

WRP schemes delivery

Non SPC Metrics

Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected
Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected

People
Patients
Productivity
Performance

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

People

Excellent care with compassion

Always Safety First

@LancsHospitals

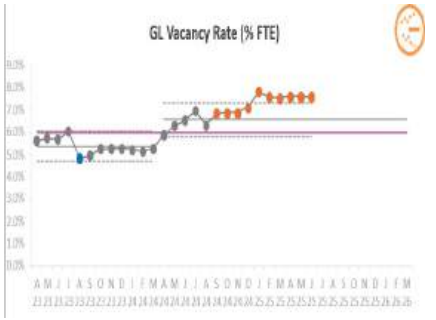
Alert, Advise, Assure Report: People

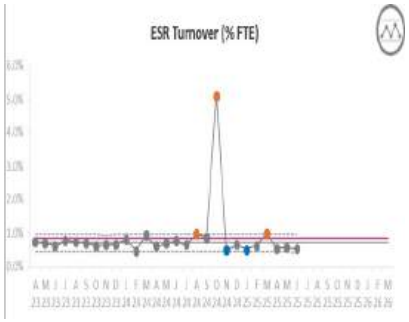
	Issue	Action
Alert Areas of concern or matters that need addressing urgently	The Trust has not yet achieved compliance for **one** mandatory training metric (Patient Safety for Boards and Senior Leadership Teams - 88%). Medical and Dental staff group mandatory training compliance remains an area of underperformance.	141 staff remain non-compliant for 'Patient Safety for Boards and Senior Leadership Teams'. Actions implemented: •All staff receive a tailored monthly compliance report via email, detailing their status across all mandatory training requirements. •Staff identified as non-compliant with any mandatory metric receive weekly reminder emails to prompt completion. •Personalised follow-up emails have been sent to staff highlighting non-compliance, emphasising the critical requirement to meet the CQC's must-do actions. •A paper outlining steps to address persistent non-compliance was presented at Workforce Committee in July, with agreed escalation and disciplinary process.
Advise Areas of ongoing monitoring and any new developments	Sickness Absence	A rapid improvement workshop was held with the clinical teams in early July which enabled best practice in absence management and opportunities for further development and best practice in absence management to be shared. The actions will inform the absence reduction strategy. Planning for Empactis implementation has now commenced with a timeline of end of August/early September for go live. Restrictions on working additional hours following sickness absence have been implemented. An additional clinical psychologist has been recruited and will commence October 2025.
Assure Areas of Assurance	Sickness Absence	Sickness absence had reduced in month to 5.88%, with improvements seen in long term sickness absence levels. This triangulates with a significant reduction in absence cases of 4 months plus duration, which provides assurance this reduction is not down to seasonal variation. A full deep dive paper was presented to workforce committee in July and was positively received.

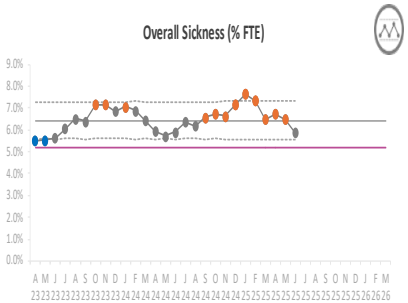
People

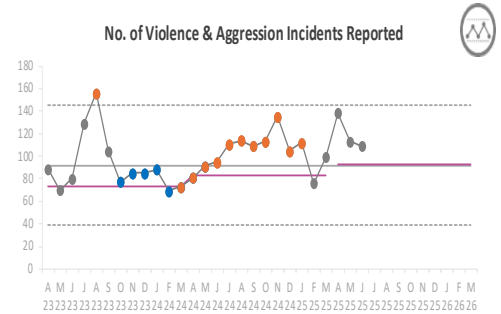
Lancashire Teaching Hospitals NHS Foundation Trust

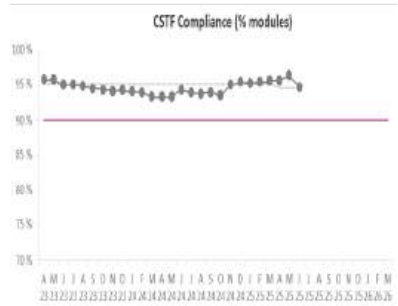
Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People	Vacancies (% FTE) (source: General Ledger)				≤ 6%		7.60%	M03
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.53%	M03
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.24%		5.88%	M03
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		109	M03
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				≥ 90%		94.56%	M03
	Appraisal compliance (% HC)				≥ 90%		90.85%	M03
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		42.30%	Q1

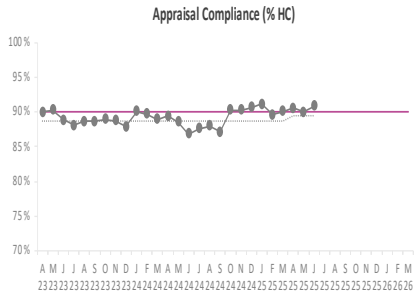


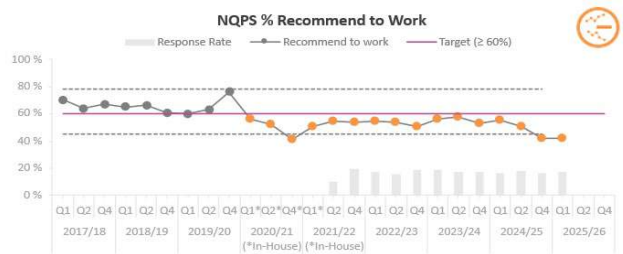












The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Patients

Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report: Patients

Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently		
Advise Areas of ongoing monitoring and any new developments	1. CQC Must do – 3 out of 18 expected to deliver by 31 July 25. All relating to mandatory training.	• Mandatory policy compliance changes agreed at Workforce committee. Implementation expected by 31 October 2025.
	2. Midwifery Support Worker fill rate has achieved an average of 88%. The service is prioritising night shifts to support and mitigate any gaps in the day. The risks associated with this are being managed.	• Recruitment is ongoing for 4.6WTE vacancies. • Sickness focus continues. • Matron safe staffing processes in place to mitigate any risks.
	3. C.difficile – National trajectory reset for 2025/26 from 199 to 167 cases. To date these remain within trajectory.	• Implementation of the national cleaning standards continues with a plan to be 50% compliant by 30 September 2025. • The Safety and Quality committee scrutinised the Infection Prevention & Control (IPC) Board Assurance Framework from NHS England as part of the annual IPC report.
	4. ENST – on track to deliver 9/10 standards. The remaining 10th standard relies upon commissioned local maternity neonatal system (LMNS) lead funding, raised with commissioners.	• Commissioning gap raised with ICB LMNS. Response expected by 31 August 25.
Assure Areas of Assurance	1. CQC Should do – 100% of the 36 recommendations delivered.	• The CQC must and should dos have been built into monitoring as part of the STSAR process.
	2. Registered Nurse, Midwife and Health Care Assistant (HCA) fill rates: Staffing levels continue to meet required thresholds.	• NMAHP safe staffing procedure are compliant with monthly and twice annual procedures. • Birthrate plus 3 yearly assessment has commenced in maternity and will be reported as part of the next bi annual midwifery staffing report.
	3. STAR Accreditation all trust- Demonstrating stabilisation following the introduction of the critical standards. As expected this affected performance and there is evidence this is now demonstrating signs of improved compliance.	• STAR Critical standards introduced in response to continued suboptimal performance.
	4. Complaints – continued reduction maintained due to increased focus on local resolution.	• The feedback and focus on concerns is leading to an increased understanding of broader themes that are affecting patient experience. • Weekly monitoring for concerns is being developed to enable divisional oversight of this to be strengthened. • The patient experience plan tracks progress against each divisions patient experience plans.
	5. Mortality – stable position with adult HSMR and SMRI rated as 'lower than expected' levels and SMRI for child and Neonatal; rated 'as expected'. Still Birth remain lower than the national average.	• Mortality processes are in place to ensure structured judgement reviews are undertaken. • Perinatal Mortality Review Tool (PMRT) and MBRRACE referrals continues to be utilised and monitored as part of the monthly maternity and neonatal report. • Incident and learning processes ensure cases where learning is present, this is identified and shared.

Patients

Lancashire Teaching Hospitals NHS Foundation Trust

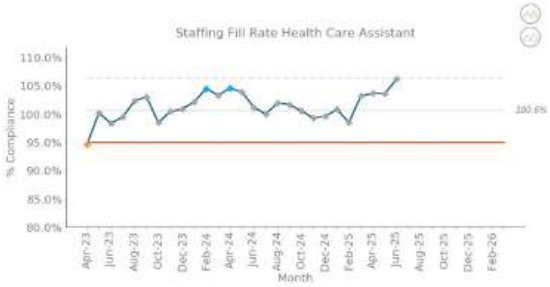
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-26	Latest Month Target		
CQC	CQC - "Must do" (Number with Green rating)				18	15	15	Jun-25
	CQC - "Should do" (Number with Green rating)				36	36	36	Jun-25
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95.0%	102.4%	Jun-25
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	106.1%	Jun-25
	Staffing Fill Rate - Registered Midwife				95%	95.0%	92.9%	Jun-25
	Staffing Fill Rate - Maternity Support Worker				95%	95.0%	86.0%	Jun-25
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	1.56	Jun-25
	STAR Accreditation all trust (Silver and Above)				75%	75.0%	82.0%	Jun-25
C Difficile Improvement	C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases				13	14	10	Jun-25
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected					73.8	Feb-25
	Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected					76.1	Feb-25
	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected					0.0	Feb-25
	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected					0.0	Feb-25
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.32	3.02	3.68	Jun-25
Maternity	Perinatal - Number of Stillbirths				0	0	1	Jun-25

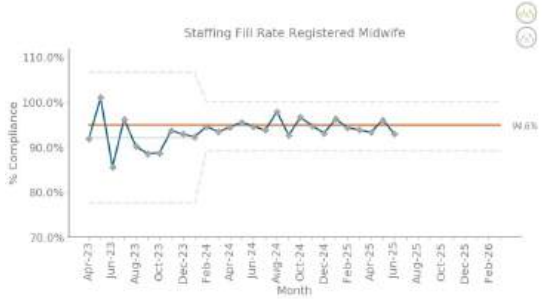
Patients


CQC - "Must Do" - Green Rating
No. of CQC actions
Month
Trajectory
Green Rating


CQC - "Should Do" - Green Rating
No. of CQC actions
Complete
Month
Trajectory
Green Rating


Staffing Fill Rate Registered Nurse
% Compliance
Month


Staffing Fill Rate Health Care Assistant
% Compliance
Month

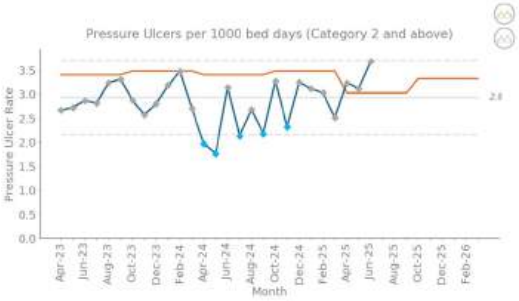

Staffing Fill Rate Registered Midwife
% Compliance
Month

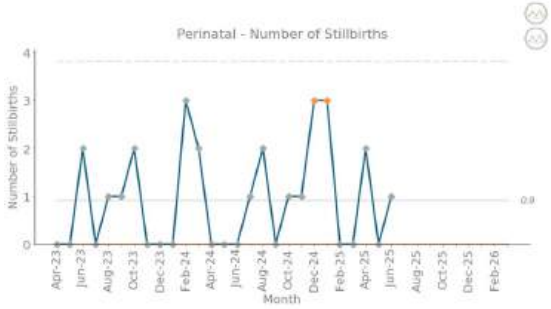

Staffing Fill Rate Maternity Support Worker
% Compliance
Month


Complaints per 1000 bed days
Complaints Rate
Month


STAR Accreditation all trust (Silver and Above)
% Compliance
Month


C. difficile performance against national trajectory - no more than 167 Hospital Acquired cases (COHA & HOHA)
Number of Patients
Month

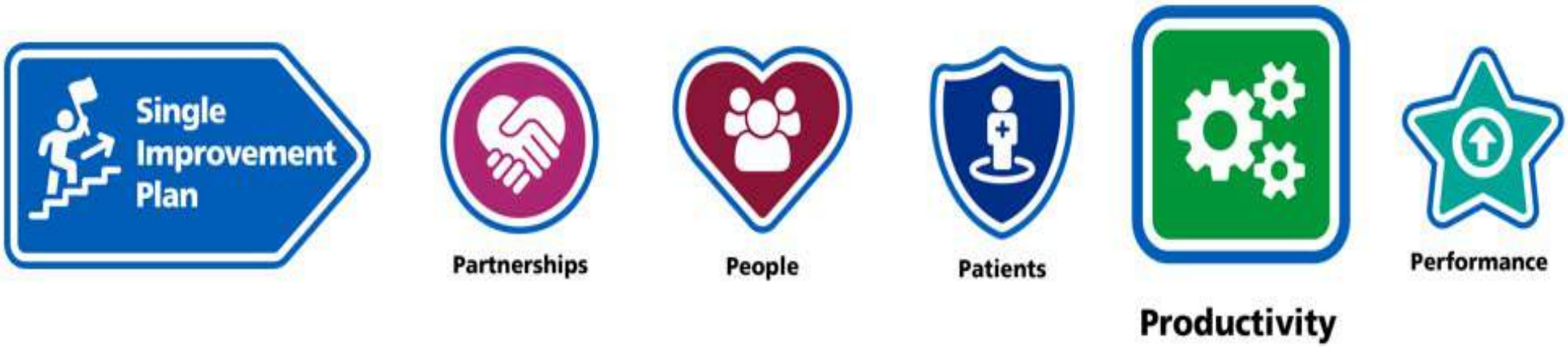

Pressure Ulcers per 1000 bed days (Category 2 and above)
Pressure Ulcer Rate
Month


Perinatal - Number of Stillbirths
Number of Stillbirths
Month

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Productivity



Excellent care with compassion
Always Safety First
@LancsHospitals

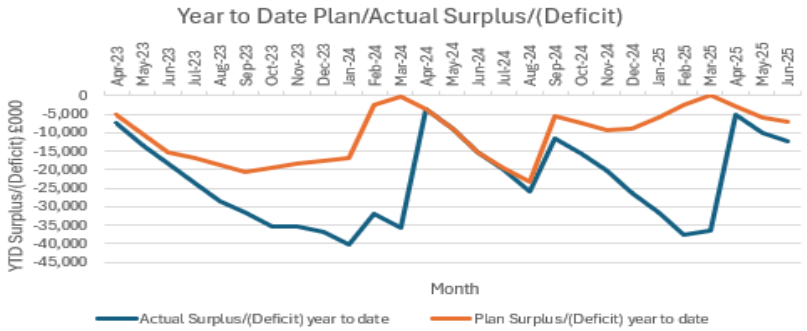
Alert, Advise, Assure Report: Productivity

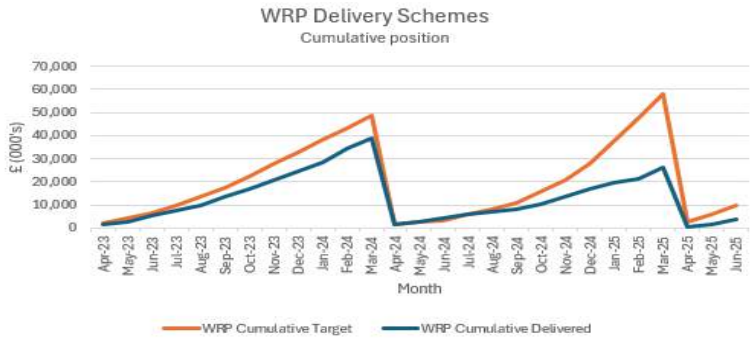
Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	1. The cash risk has been increased from significant to high. Cash continues to be challenged and the Trust will require support in September particularly as the phasing of the efficiency programme has changed from the original plan.	1. Cash committee meeting in August - will review prioritisation list if national cash support is not forthcoming as well as the paperwork for the September request 2. Informal contact has been make with the regional team who vet the Trust's submission before forwarding to the national team 3. The cash submission will be made in August for the September request 4. Management of the efficiency programme to ensure efficiencies are cash releasing 5. Utilisation of capital cash for revenue purposes as a short term measure
Advise Areas of ongoing monitoring and any new developments	1. The Trust has a break-even financial plan which is reliant on a recurrent waste reduction programme of £60m and non-recurrent deficit support funding of £30m 2. At the end of June 2025 the Trust has a deficit of £12.5m against a planned deficit of £7m. The adverse variance to plan of £5.5m is as a consequence of the shortfall in delivery of the waste reduction programme. The shortfall in the programme at the end of June was £5.9m. 3. The Trust has operational pressures in: a) the acute medical pathways reflected in overspends in medical and nursing pay budgets b) Sickness remains higher than in operational budgets resulting nursing pay overspends 4. At the end of June the Trust has delivered £10.2m of the £60m efficiency target (17%). 5. The Trust is in segment 4 of the current national operating framework and is receiving mandated support through the Recovery Support Programme. The operating framework is expected to change in the near future.	1. The Trust has a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities 2. The Trust has re-set the programme structure, governance and reporting for 2025/26 and in Q2 is moving into a focus on delivery now that the programme has been identified 3. The Trust has commissioned further external support for specific financial recovery plan workstreams and 2025/26 waste recovery programme development 4. The Trust is building its own project management office structure to have a sustainable solution moving forward 5. The Trust is working with the ICB on the urgent and emergency pathway system pressures 6. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies, scrutiny of non-pay requirements and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.
Assure Areas of Assurance	1. At the end of June the Trust has identified schemes and opportunities to the value of £60m for the waste reduction programme however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6 months of the year. Over 80% is in low or delivered and is recurrent 2. Capital expenditure in the year to date is marginally below plan but plans are in place to deliver a forecast matching the available capital funding	

Productivity

Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target (£ 000's) Concern	Mar-26	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Productivity	I&E - Plan v Actual variance					-7012	-12471	Jun-25
	WRP schemes delivery				60000	9498	3582	Jun-25





The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Performance

Excellent care with compassion

Always Safety First

@LancsHospitals

Alert, Advise, Assure Report: Performance

Lancashire Teaching Hospitals NHS Foundation Trust

	Issue	Action
Alert Areas of concern or matters that need addressing urgently	• Ambulance handover performance (15/30 and 60 mins) - whilst improvements in performance have been seen in June in all handover areas, performance remains below the national and Trust targets for 25/26. • RTT performance (18, 52 and 65 weeks) - key speciality pressures inc ENT, Surgical Dentistry, Neurology , Plastics, Vascular, Pain, T&O, Oral Surgery, Neurosurgery and Cardiology • Days Kept Away from Home (DKAFH) and Boarding - Average of 25 patients boarded in June - slight increase versus May.	• Key actions being taken to improve ambulance handover performance includes increasing 'Fit to Sit' practices, improve data capture with NWAS, increased flow out of ED via continuous flow 'cycles' every 30 mins to AMU. 45 minute release to rescue commences 1st Aug 25 and actions will see a reduction in over 60 min waits. • RTT - administrative and clerical vacancies are being released to recruitment to support increased validation, some increased short term capacity will be mobilised in Aug 25 in addition to Locum recruitment and increased utilisation. • DKAFH/Boarding - Further roll out of the Lancs Improvement methodology and DKAFH cultural change programme to maximise the benefits and LOS reductions.
Advise Areas of ongoing monitoring and any new developments	• 12 hour + ED LOS - whilst performance has deteriorated in June marginally (-0.44%) delivery exceeds the 25/26 target. • Cancer performance - latest validated performance (April) shows under performance against all cancer waiting time targets - key modalities include urology, lung, colorectal, breast and oncology. Drivers of under performance relate to capacity shortfalls, workforce gaps, increased demand and late referrals.	• 12 hour + ED LOS - Key focused action re Continuos flow and DKAFH. • Cancer performance - Seek to recruit into Locum posts to support Breast tumour group, reducing pathology turnaround times and increase diagnostic capacity EBUS - Aug 25 implementation and Endoscopy - linked to business case approval. Work is ongoing with the ICB to mitigate increased oncology demand.
Assure Areas of Assurance	• DM01 - whilst the Trusts performance is in the lowest decile nationally, the Trust has seen 3 months performance exceeding target. Key driving modalities include Echocardiology, endoscopy, NOUS and CT. • 4 hour ED performance (all) - performance has been above the 25/26 target for the 3rd month and is a static position. • Bed Occupancy - whilst current occupancy levels are above the nominal best practice levels of 85%, improvements monhtly have been noted for the last 4 months with the occupancy target being below the 25/26 target levels	• DMO1 - Key improvement actions include improved utilisation - endoscopy has seen a 2.5% improvement in 6 week compliance via increased booking capacity and reduced DNAs. Validation continues and will increase against all modalities. Capital equipment bids have been successful and will support echo with an additional bid to develop a cardio respiratory hub at CDH due to be considered mid Sept 25. A revenue business case has been approved at TMB to support increased capacity and performance in Endoscopy and will be considered at Board in August 25. • 4 hour performance & Bed occupancy - Recruitment into key medical vacancies will support improvements in the wait to be seen time - likely impact end Q3. DKAFH cohort wards are in place and data analysis is showing reducing days lost when fit specifically within pathway 2 by adopting a strengths based approach - scoping of further expansion and wider training roll out across further wards.

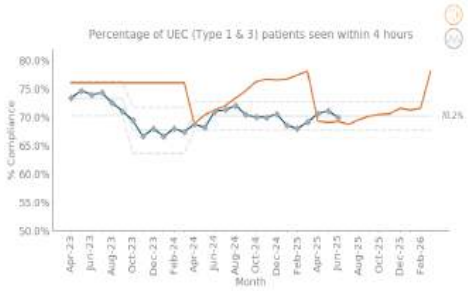
Performance

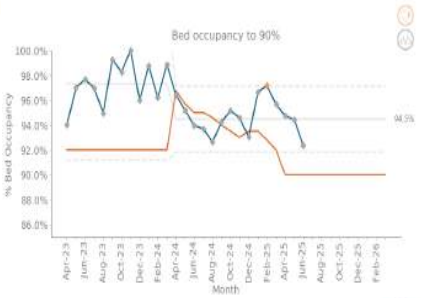
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Concern	Target Mar-26	Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100.00%	100.00%	90.14%	Jun-25
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				78.03%	69.21%	69.92%	Jun-25
	Maximum wait of 12 hours as Total Time in Department				8.20%	13.03%	10.96%	Jun-25
UEC Flow	Bed occupancy to 90%				90.00%	90.00%	92.37%	Jun-25
	Number of boarded patients				0	0	25	Jun-25
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to !				4.70%	11.10%	10.93%	Jun-25
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				65.00%	56.50%	60.45%	Jun-25
Elective (long waits)	Percentage of patients waiting less than 18 weeks				62.50%	57.94%	54.91%	Jun-25
	RTT - 52 week Waiters				1304	1419	2068	Jun-25
	RTT - 65 Week Waiters				0	0	22	Jun-25
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				84.58%	84.58%	84.04%	Jun-25
Elective (Cancer)	31 Day Cancer Standard				95.98%	87.50%	88.63%	Jun-25
	Cancer 62-day performance				75.10%	61.11%	57.51%	Jun-25
	Cancer Faster Diagnosis Performance				80.01%	80.00%	83.61%	Jun-25

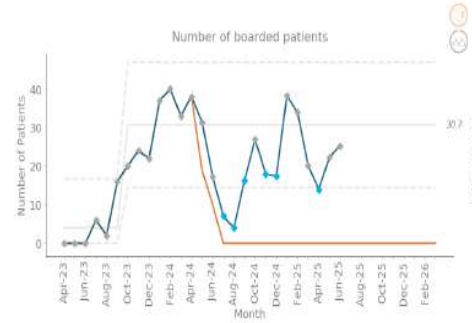
Unvalidated position, subject to change

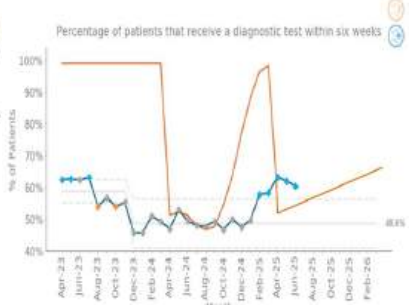
Performance

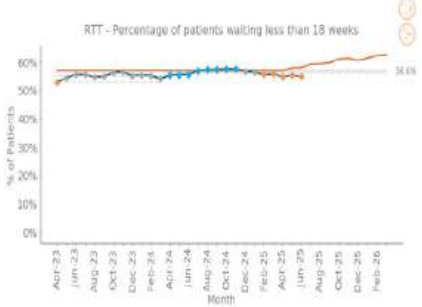
Lancashire Teaching Hospitals NHS Foundation Trust

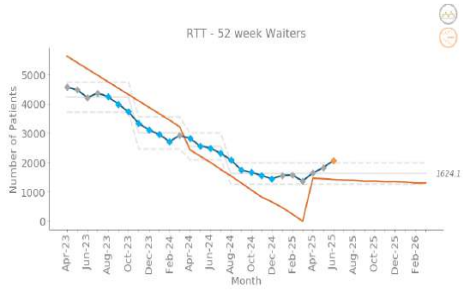


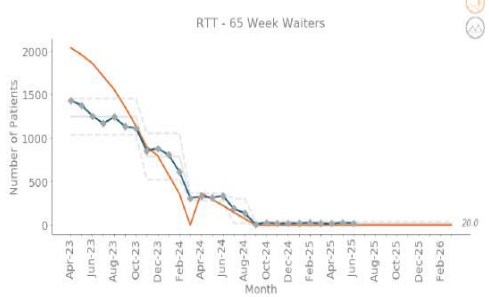


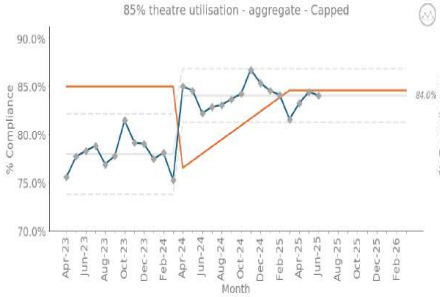


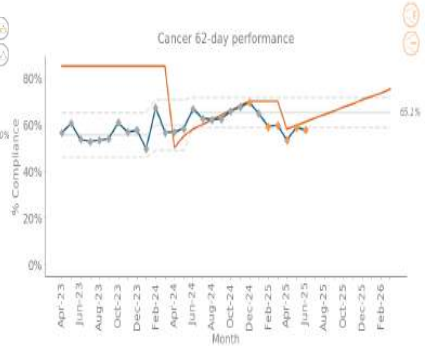


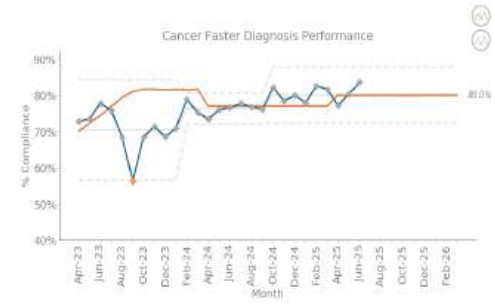


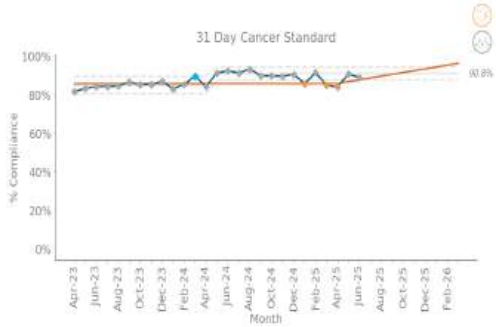












The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

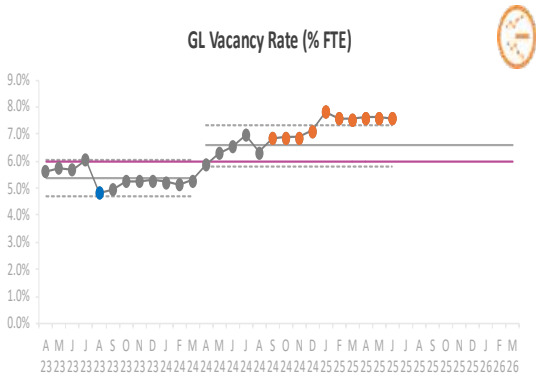
Integrated Performance Report
Appendix 1 – Assurance Reports

August 2025 Trust Board meeting with performance to June 2025

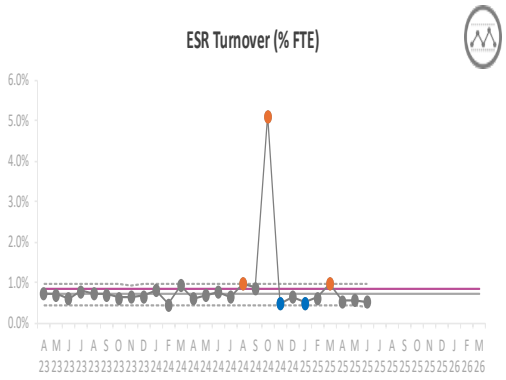
Excellent care with compassion

Always Safety First

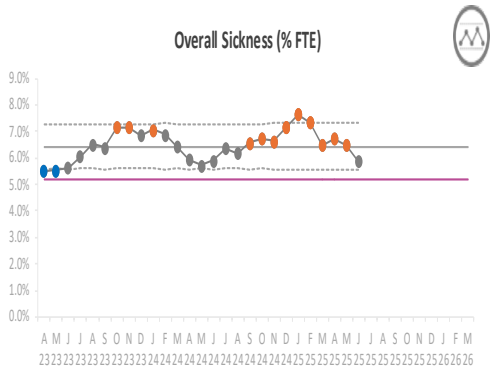
People - Workforce Assurance 1



Latest
7.60%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation



Latest
0.53%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 10%
Target Achievement
Could both pass or fail target within expected variation

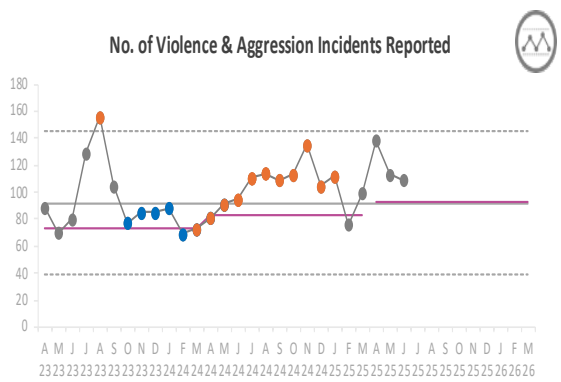


Latest
5.88%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 5.24%
Target Achievement
Will consistently fail the target within expected variation

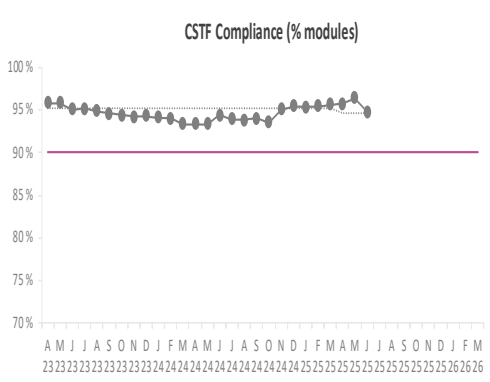
Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures, posts continue to be filled on an internal only redeployment first basis, with only essential posts have been released for external advert.	Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams, including apprenticeship options. .	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision-making
Turnover (% FTE)	In-month turnover remains within target.	Leaver and exit interview data continues to be monitored to identify any patterns or themes of concern. Any issues are escalated to HRBP colleagues and themes/trends discussed through the Monthly Recruitment and Retention Group and Divisional Workforce Committees. New Stay Conversations launched via corporate forms with guidance communicated through Monthly Managers Update Sessions. Some initial uptake has been seen - further work required to embed across Trust. New starter Forums planning underway for delivery in July to understand colleague experience during onboarding/first year.	Annual retention strategy update report provided to Workforce Committee. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas. 6 monthly retention updates provided to Divisions.
Sickness Absence (% FTE)	Sickness Absence has reduced in month to 5.88%.	A rapid improvement workshop was held with the clinical teams in early July which enabled best practice in absence management and opportunities for further development and best practice in absence management to be shared. The actions will inform the absence reduction strategy. Planning for Empactis implementation has now commenced with a timeline of end of August/early September for go live. Restrictions on working additional hours following sickness absence have been implemented. An additional clinical psychologist has been recruited and will commence October 2025.	Sickness absence had reduced in month to 5.88%, with improvements seen in long term sickness absence levels. This triangulates with a significant reduction in absence cases of 4 months plus duration, which provides assurance this reduction is not down to seasonal variation. A full deep dive paper was presented to workforce committee in July and was positively received.

People - Workforce Assurance 2

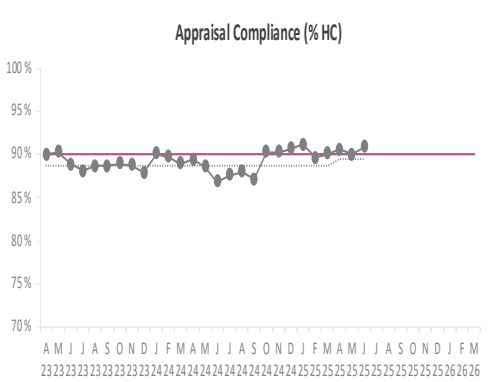
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
109
Variance Type
Normal variation - no recent change
Mar 26 Target
NA
Target Achievement
Could both pass or fail target within expected variation



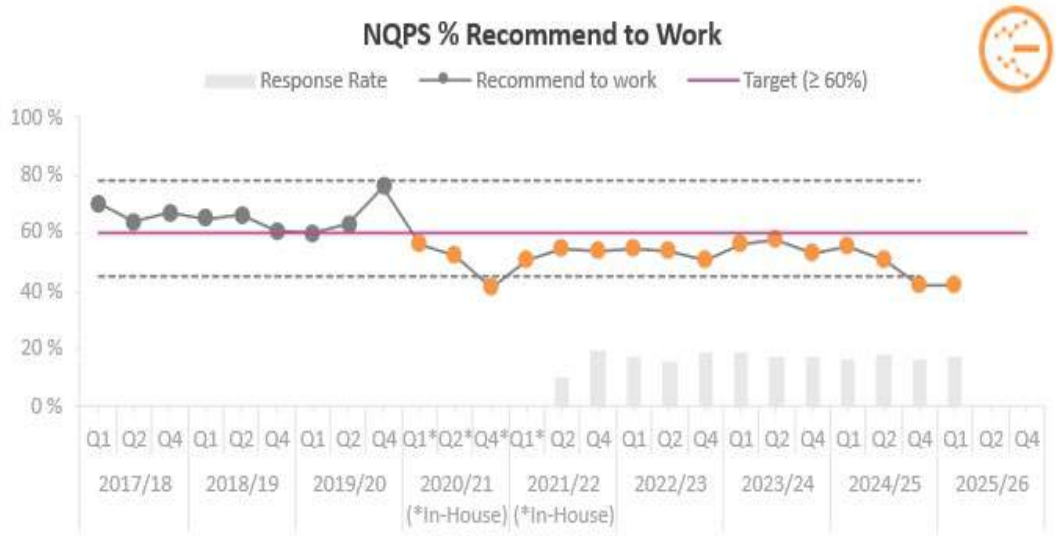
Latest
94.56%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement



Latest
90.85%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Incidents have reduced in month.	Monthly meetings established for Emergency Department with clinical, security and workforce representatives to review actions and learning from recent incidents Security presence increased in ED with the aim of 24/7 cover, and an assessment of all other security measures underway Liaison between Resilience leads and police recently strengthened Violence and aggression risk assessment for wards/departments reviewed by Big Room was relaunched in June Violence marker process being reviewed through the Big Room with Safeguarding involvement, with a particular process on how accessible information is to the clinical teams.	Twice-yearly deep dive reports around incidents and actions to Workforce Committee Incident data reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Overall Trustwide Core Skills and Mandatory training compliance is 94.56%. The Trust is compliant in 32 out of 33 metrics. Patient Safety for Boards and Senior Leadership Teams has not yet achieved Trustwide compliance (88%).	141 staff remain non-compliant for 'Patient Safety for Boards and Senior Leadership Teams'. A paper outlining steps to address persistent non-compliance was presented at Workforce Committee in July, with agreed escalation and disciplinary process.	High levels of engagement at divisional level and targeted intervention is positively impacting Trustwide compliance.
Appraisal compliance (% HC)	Appraisal compliance was 90.85% which is above the target of 90%. Areas with the lowest compliance include Hosted Services and Estates and Facilities Management.	All Divisions and Department have received Appraisal compliance data via Workforce Business Partner and Education Compliance Teams, asking to develop plans to achieve 90%. Trust wide communications have been sent to all colleagues with regards to the Standard Operating Procedures which are now being deployed with regards to centralised close when Appraisal target dates have passed however appraisal not closed in a 4 week time period.	Annual Appraisal Update presented to Workforce Committee in May 2025. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

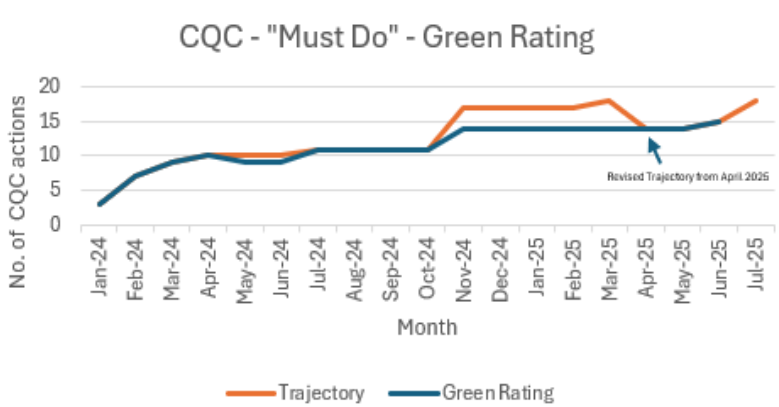
People - Workforce Assurance 3



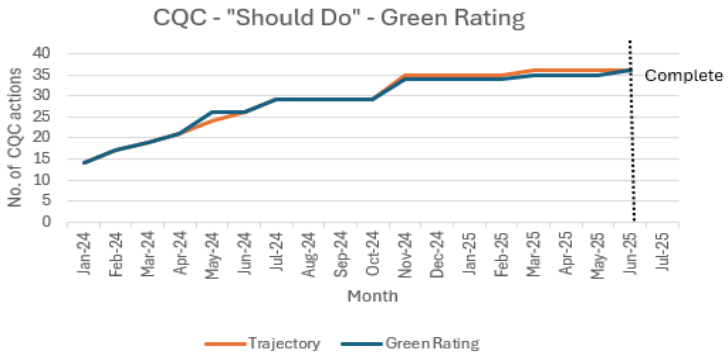
Latest
42.3%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≥ 60%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	**Please note: This is a quarterly metric; therefore, there is no update this month. The data remains unchanged from that reported in April's PC Assurance Dashboard** April: There has been a further drop in levels of colleague engagement in the Quarter 4 National Quarterly Pulse results (NQPS), in Q2 it was 51%, in Q3 49.4%, through to the most recent Q4 at 42.1%. There is a significant deterioration in levels of satisfaction and engagement. The Q4 data reflects the themes identified in the full NHS Staff Survey Results for 2024.	A corporate-level action plan, developed in response to the NHS Staff Satisfaction Survey, was presented in May and approved by the Workforce Committee. The plan focuses on addressing areas of dissatisfaction that are contributing to lower levels of colleague engagement, as reflected in the Quarter 4 (Feb 2025) National Quarterly Pulse Survey data. Survey results have been shared through multiple forums. All Divisions, Departments, and Managers have been asked to review their local results and develop targeted action plans to drive improvement. A comprehensive communication plan is in place, with weekly updates and targeted interventions currently being delivered across a range of workstreams.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.

Patients - CQC Assurance



Latest
15
Month Target
15
July-25 Target
18

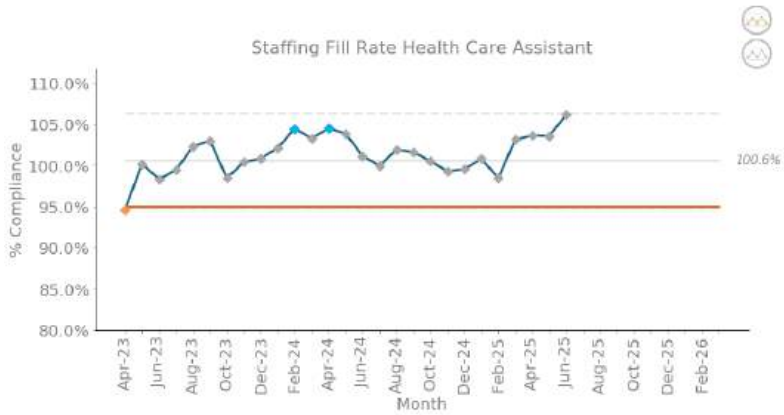


Latest
36
Month Target
36
July-25 Target
36

Metric	Summary	Action	Assurance
CQC - "Must do" (Number with Green rating)	At the end of June 2025, of the 'Must Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), 51, 94% of Must do actions are delivered. 3, (6%) actions have changed from 'amber-red' to 'amber-green' . There are no actions currently assessed as "amber-red" or 'Red' i.e. not expected to deliver at any point in time.	1. Rates of appraisal and training: Compliance continues to be monitored monthly. There has been positive improvements with overall training compliance. The Trust are above the target for all Core Skills subjects. In relation to the three 'Must Do' actions associated with training, training for Medical and Dental, and nursing staff, for specific core metrics in urgent and emergency care remain undelivered at the end of June 2025, however, improved performance has been observed for both staff groups. At the of June 2025, nursing staff were compliant in 17 out of 20 training metrics, and medical and dental staff were compliant in 13 out of 19 training metrics. For medicine, at the end of June 2025 the data reflected improved compliance for all resuscitation and sepsis training for medical and nursing staff in comparison to at the time of the inspection. Nurse training compliance was 90% or above for all resuscitation training metrics and sepsis training. For medical staff, there was a 47% increase in compliance for Advanced Life Support (ALS) training at the end of June 2025, significantly improving the overall compliance to 80%. Whilst the compliance is not yet at 90%, the position now exceeds that at the time of the inspection (68%). There has also been an improvement in medical training compliance for sepsis at the end of June 2025. Again, whilst the compliance is not yet at 90%, the position of 88% exceeds the compliance at the time of the inspection (54%). 2. Fluid balance and vital signs monitoring: Regarding the accurate and timely documentation of fluid balance and NEWS documentation within UEC RPH, weekly audits of NEWS and fluid balance commenced from May 2025. Since commencing the weekly audits in May 2025, the monthly NEWS audit for May 2025 demonstrated a compliance of 100%, and for June the compliance was 95%. The monthly fluid balance audit for May 2025 reflected a compliance of 93%, and 91.4% at the end of June 2025. Given that performance has been sustained for two consecutive months above 90%, the action has been marked as delivered. The weekly ED audits of NEWS and fluid balance will continue to provide ongoing assurance and oversight. Performance will continue to be monitored through the STAR quality assurance framework and as part of the Single Improvement Plan.	From the 18 'Must Do' recommendations, 15 have been assessed as delivered and the themes of the 3 outstanding 'Must Do' recommendations are related to staff training compliance in urgent and emergency care and medicine.
CQC - "Should do" (Number with Green rating)	At the end of June 2025, of the 'Should Do's' included in the 2023/2024 CQC QIP, 100% of should do actions are delivered.	1. For timely medical review when not receiving care on the correct medical ward, the daily manual audit was continued throughout June 2025. The compliance with daily medical review for medical outliers remained 100% at the end of June 2025. Overall since the audit commenced in April 2025, 300 cases of medical outliers have been audited with an overall compliance of 100% with daily medical review. Given the sustained performance, the action has been marked as completed. Data quality issues remain with the ClinDoc data therefore, the manual audit will continue whilst a digital solution to obtaining the data is identified and the data validated.	From the 36 'Should Do' recommendations, 36 have been assessed as delivered at the end of June 2025.

Patients - Deliver Annual Safe Staffing Requirements Assurance

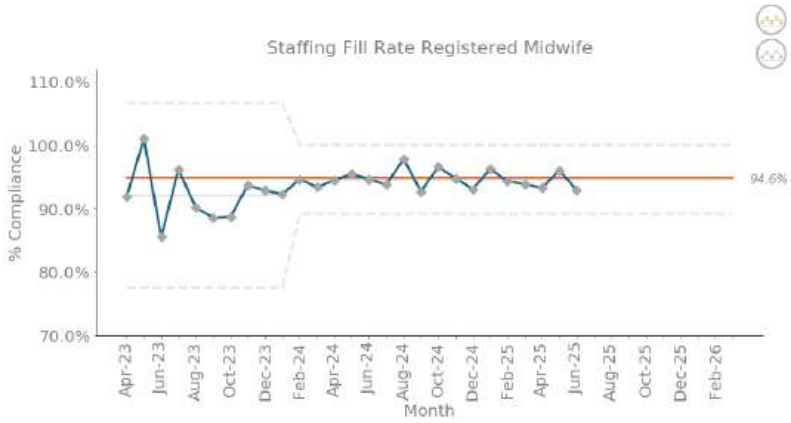
Latest
102.44%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation



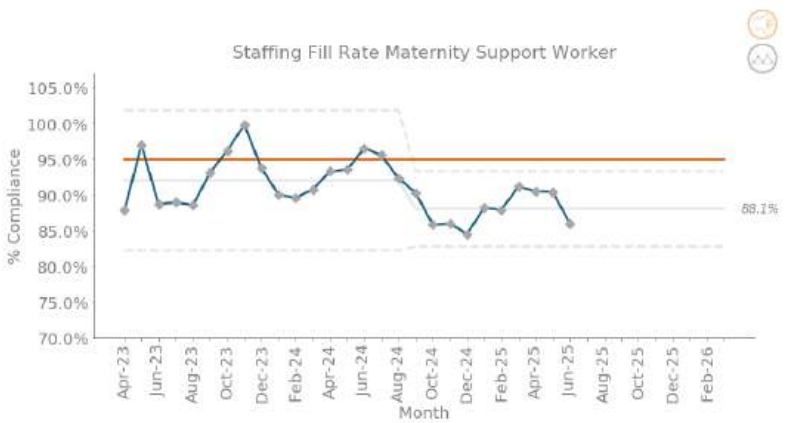
Latest
106.13%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for inpatient wards in June was 102%. At site level, Chorley District Hospital (CDH) achieved a RN fill rate of 105%, while Royal Preston Hospital (RPH) reported a 102% RN fill rate. Additional duties are created in both Emergency Departments to respond to occupancy levels and to maintain safety, this results in an over established fill rate. The implementation of strengthened approval processes for bank and agency is in place, while maintaining safety for patients and staff.	1. Ward managers work clinically as part of the clinical establishment with Matrons, when required, to support patient care. 2. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders 3. Service need and review of elective surgical services at CDH. 4. Redeployment of staff into vacancies through organisational change and ward closers.	1. Overall fill rate on average is between 112.4% and 85.7%. All clinical areas are showing a stable fill rate position. The Surgical ward staffing needs fluctuate depending, no concerns have been noted relating to safety and quality of care with a planned review across elective services to be undertaken. 2. Daily operational staffing meetings led by matrons, assess and respond to changes in pressure and demand based on acuity and dependency, Red flags and professional judgement. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report. 6. Involvement in National Enhanced Therapeutic Observation and Care (ETOC) improvement work.
Staffing Fill Rate Health Care Assistant	The HCA staffing fill rate for inpatient wards in June was 106%. At site level, Chorley District Hospital (CDH) scheived a HCA fill rate of 102%, while Royal Preston Hospital (RPH) reported a 107% HCA fill rate. Additional duties are created in both Emergency Departments to respond to occupancy levels and to maintain safety, this results in an over established fill rate.	1. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank use. 2. A review of Band 2 and Band 3 roles is being undertaken in line with national role guidance. 3. Introduction of apprentiships into vacancies has commenced in the inpatient wards. 4. Redeployment of staff into vacancies through organisational change and ward closers.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



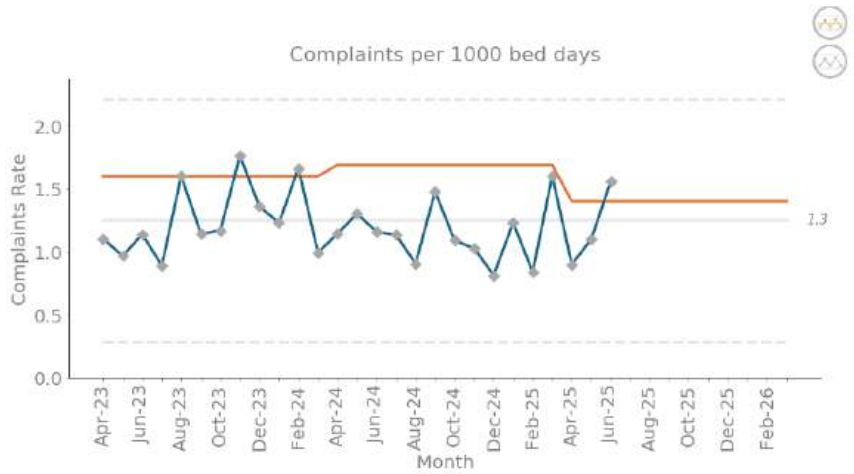
Latest
92.87%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
85.99%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The fill rates for Registered Midwives in June 2025 demonstrate a stable position overall. The midwifery vacancy is 10.99 WTE with a further 6.86WTE posts available to align the service with Birth Rate Plus recommendations. Midwifery jobs have been advertisted and shortlisted. 48 candidates are being interviewed on 5th and 6th August. In addition an advert for core positions on the maternity ward is now out to advert and interviews for these will be held by the beginning of August. It is hoped that the service will be able to fully recruit to all vacancies Vacancies continue to result in bank and agency spend associated with Delivery Suite, Maternity A and B and Maternity Assessment Suite. The next BirthRate plus assessment for the service has commenced.	1. Daily Safety Huddles led by matrons respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Ward managers work clinically in addition to the 80/20 split when required during periods of high activity or reduced staffing. 3. Weekly roster efficiency reviews to ensure appropriate use of bank and agency. 4. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory. 5. Over offer plan in place to close the gap as part of the next cycle of recruitment.	1. Fill rates for registered midwives overall have been stable across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 6. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.
Staffing Fill Rate Maternity Support Worker	Fill rates for MSW's is below target. Continuing long term sickness on maternity A and community services is being managed in line with the Trust Policy. To maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts. The implementation of the strengthened approval and oversight processes for bank and agency approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. There has been an improvement in MSW vacancy with a current vacancy of 1.64 WTE for Band 2 and 2.97WTE Band 3 MSWs made up of vacancy and maternity leave. Recruitement is ongoing.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Weekly roster efficiency reviews to ensure appropriate use of bank. 4. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory 5. Sickness management procedures reviewed by Workforce BP to ensure appropriate management. 6. Night shifts are prioritsed to ensure periods when less additional support can be accessed are staffed appropriately.	1. The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis. 2.. Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 3. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 4.. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 5. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.

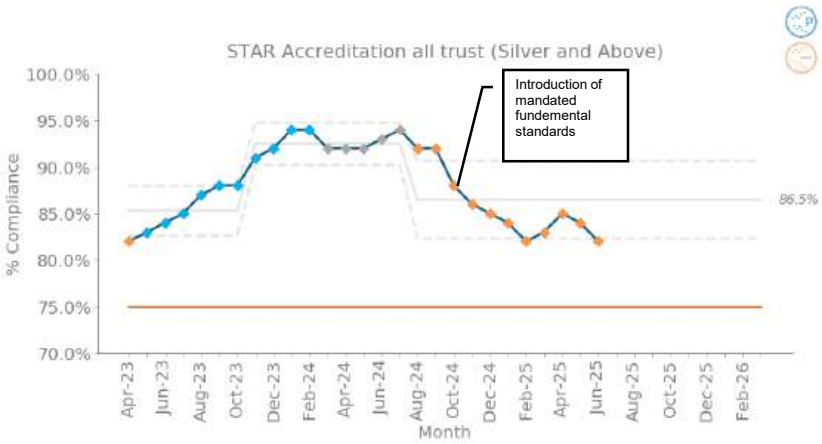
Patients - Patient Experience and Involvement Assurance



Latest
1.56
Variance Type
Normal variation - no recent change
Mar-26 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	The number of complaints per 1000 beds days continues to demonstrate a sustained reduction. This positive trend reflects an increased focus on achieving local resolution for patients and their families, enabling concerns to be addressed promptly and effectively at the point of care. Improving patient experience remains a key focus. Targeted efforts are underway as part of the Urgent and Emergency Care (UEC) improvement plans and enhancements to inpatient pathways. Insight from the national inpatient and ED surveys have provided specific areas of focus and feedback from patients, informing immediate and longer-term actions. It is acknowledged that the UEC pathway has significant impact on the overall experience of patients, families and staff and as such remains a key priority within the Trusts patient experience improvement plan. The top themes from complaints relate to communication, delays in treatment, delays in procedures and delays in appointments. The continued focus on delivery of the trust Single Improvement incorporates the ongoing patient experience plan. The continued delivery of actions in response to feedback within the national inpatient survey, urgent emergency care, cancer care and maternity.	1. Continue to deliver the Patient Experience Plan 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions in relation to National picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

Patients - Quality Assurance STAR Accreditation

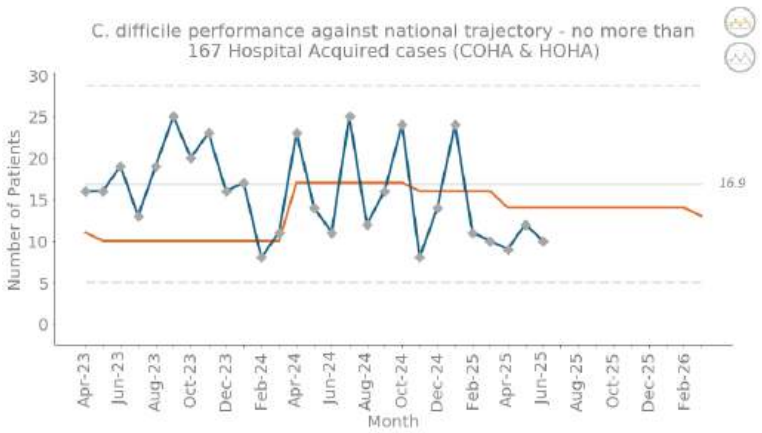


Latest
82.00%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

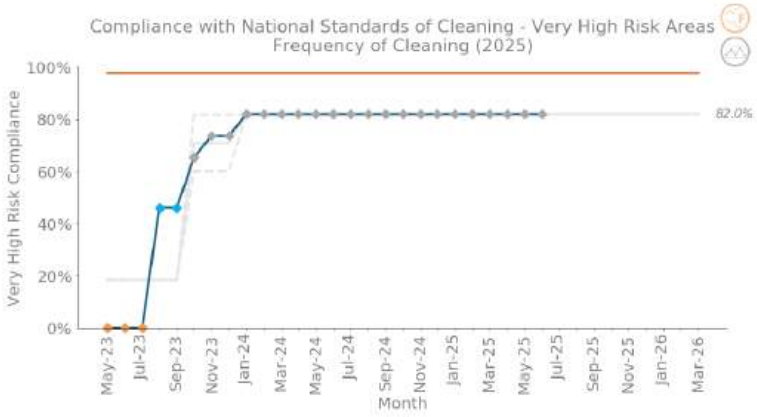
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 118 clinical areas registered for the STAR Quality Assurance Framework, of which all 118 have received STAR accreditation visits. There are no clinical areas with a red star rating, 21 areas with an amber rating and 97 areas rated green. This results in 21 bronze stars, 18 silver stars (of which 3 have acheived 3 consecutive silver stars and are awaiting the gold approval panel) and 79 gold stars. There are 82% of areas rated silver or above. During June, there were 4 areas with a reduced STAR rating, 2 areas had an increase to silver and others maintained their star rating . There was 1 clinical area who each acheived their third silver star allowing them to apply for gold star status. Two areas had a reduced 15 steps rating from A to B, the others maintained their current rating. Themes for improvement include patient experience due to boarding and overcrowding , staff and learner feedback due to capacity, staffing pressures, and low morale regarding financial pressures and uncertainty around job security. Recurrent themes included within the STAR action plan include escalation of deteriorating patients, fluid balance management, risk assessments, assessment and delivery of enhanced levels of care, mandatory training and IPC key standards. There are 92 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance porcesses and via STAR monthly reviews and STAR acreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings, the always safety first learning and improvement group and estates and facilities partnership board. The STAR report now includes CQC (2023) actionplan standards. 3. The STAR action plan has been updated to include recurrent themes and now included learning and actions from the Safety Visits undetaken by the senior leadership teams. 4. Medicine DND met with Quality Assurance Matron and Lead in June to review actions and improvement plan to strengthen actions and support for repeated bronze areas. 5. ED STAR monthly review has had additional metric added in form June to capture actions relating to nurse in charge documentation and assuracne checks including fire safety 6. Monthly meetings with DND, Matron & Ward/Department lead with 3 area's currently scoring a bronze rating with a supportive improvement action plan in place. Review of overdue actions tracked through 1-1's.	1. The STAR report is shared within the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation. 5. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 3 months.

Patients - C Difficile Improvement Programme Assurance

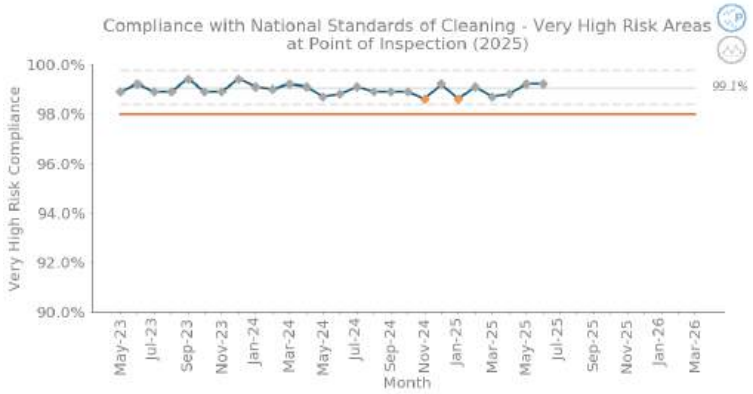
NHS Lancashire Teaching Hospitals NHS Foundation Trust



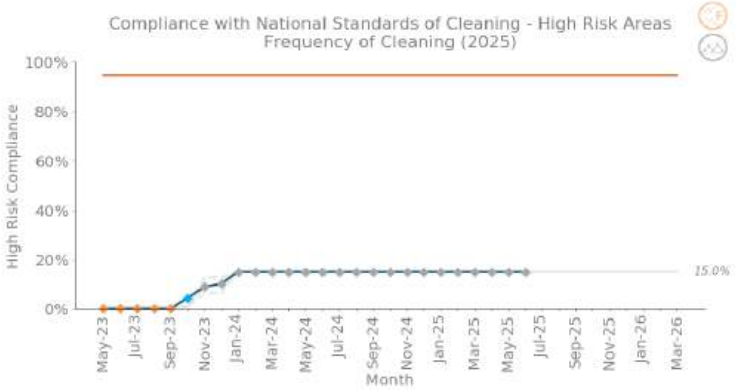
Latest
10
Variance Type
Normal variation - no recent change
Mar-26 Target
13
Target Achievement
Could both pass or fail target within expected variation



Latest
82.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
98%
Target Achievement
Will consistently fail target within expected variation



Latest
99.20%
Variance Type
Normal variation - no recent change
Mar-26 Target
98.00%
Target Achievement
Will consistently pass target within expected variation



Latest
15.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases	The increase in C.difficile is a recognised high risk and forms part of the principle risks for the organisation. During June 2025 there were 10 cases for the month, continuing the trend below the objective, with a total of 31 cases for 2025 / 2026 to date. The Trusts National objective for 2025/2026 is a total of 167 cases The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Prevention and Control Committee and aslo the Estates and Clinical Partnership Board. The National Standards of Healthcare Cleanliness (2025) for frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achieving the frequency of cleaning standards.	1. Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025). 2. Continued focus on IPC in practice through STAR monthly and accreditation processes. 3. Continue to monitor key performance assurance indicators through Infection Prevention and Control committee.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances.

Patients - Always Safety First Assurance

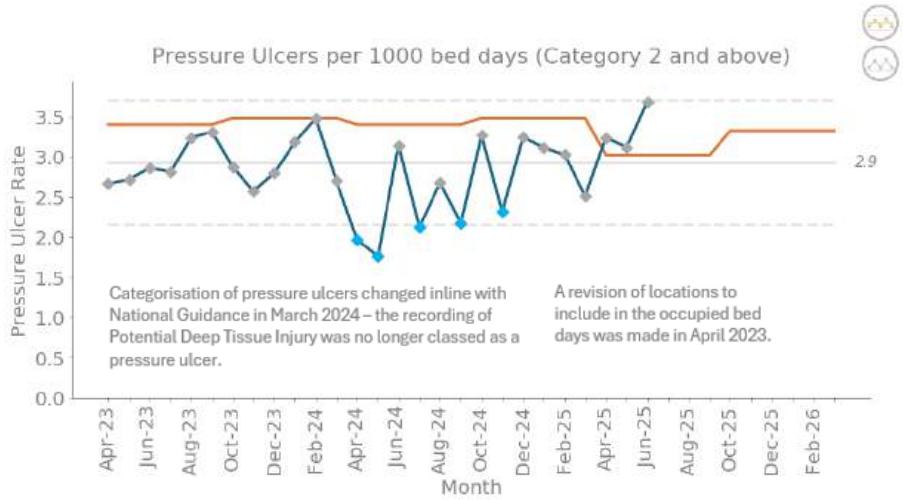
NHS Lancashire Teaching Hospitals NHS Foundation Trust

	Achievement	Position	Month
Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected	73.8	February 2025
Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected	76.1	February 2025
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected	0.0	February 2025
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected	0.0	February 2025

* SOURCE DATA: Telstra (Dr Foster)

Metric	Summary	Action	Assurance
Hospital Standardised Mortality Ratio (56 Basket – Adult)	HSMR is within Upper and Lower Control Limits and within the expected range compared to peer.	1. Continue with structured judgement review process. 2. Use mortality reviews to establish themes where care or experience could be improved. 3. Continue to work with the medical examiners office to review deaths in line with guidance. 4. Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). 5. Continue to implement the 10 CNST safety actions for maternity and neonatal 6. Marthas rule (Call for Concern)implementation is underway.	1. Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. 2. Twice annual reports to safety and Quality committee. 3. Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. 4. Speak Up arrangements are well established in the organisation. 5. Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. 6. The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. 7. ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas.
Standardised Mortality Rate (All Diagnoses – Adult)	SMR is within Upper and Lower Control Limits and within the expected range compared to peer.		
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		

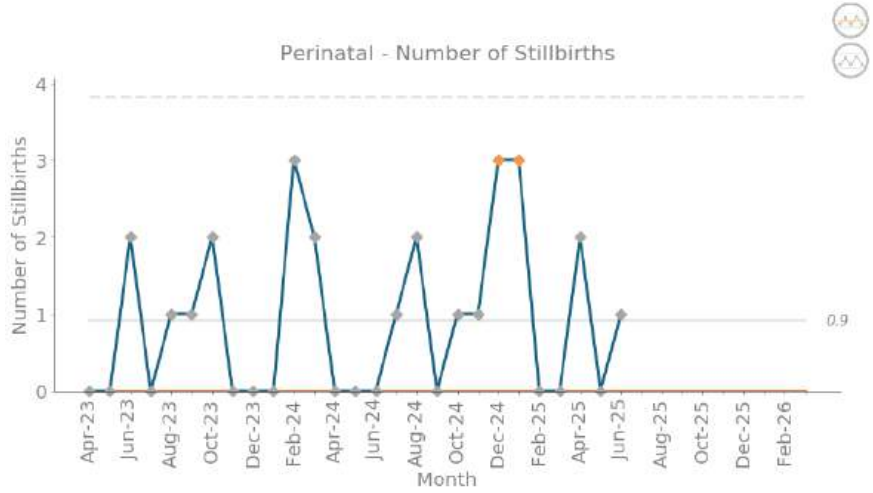
Patients - Always Safety First Assurance



Latest
3.68
Variance Type
Normal variation - no recent change
Mar-26 Target
3.32
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers are considered a proxy of care delivery. The target line has been set to reflect the average numbers of incidents over the previous 3 years, this has been adjusted from April 2025 to represents the average number of pressure ulcers in the previous year. Following the National changes in March 2024, pressure ulcer incidents have remained below the target. A continued focus on the care interventions that reduce the likelihood of pressure ulcers continues. This work will remain a priority for the Trust.	1. Organisational pressure ulcer improvement plan lead by the Deputy Chief Nursing Officer 2. Continued focus on Operational Performance Single Improvement plan. 3. STAR quality assurance fundamental standards includes intentional rounding which is linked to pressure relife interventions. 4. Education and awareness of pressure ulcer prevention continues throughout the Trsut. 5. Sharing of cross divisonal learning is divisonal always safety first meetings	1. Always Safety First strategy reporting twice yearly to safety and quality committee. 2. Always Safety First committees at divisional level responsible for overseeing the implementation of the codesigned pressure ulcer improvement programme. 3. Monitoring of pressure ulcer incidence monthly continues to be recognised as a priority metric.

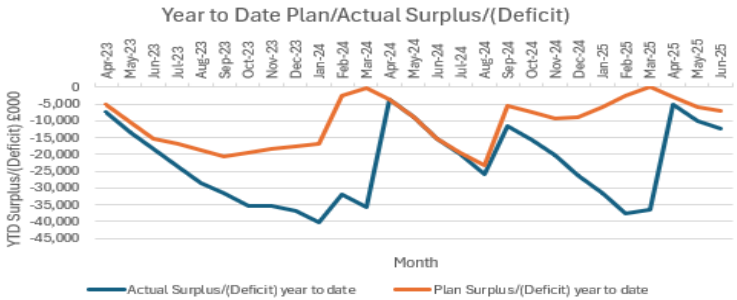
Patients - Maternity Assurance



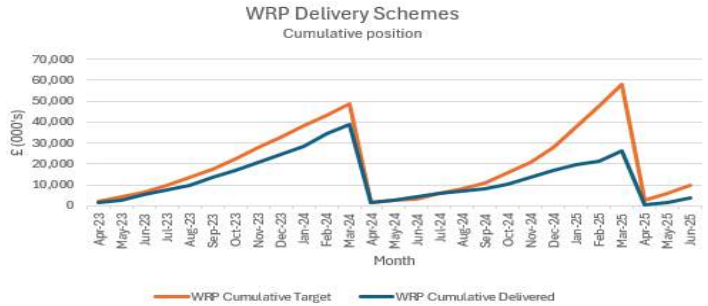
Latest
1
Variance Type
Normal variation - no recent change
Mar-26 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	The new Year 7 CNST standards have been published and although safety bundles and monitoring are continuous, new elements are included in the updated matrix. As per the year 6 maternity incentive scheme, the Integrated Care Board (ICB) /Local Maternity and Neonatal System (LMNS) assurance visits will be undertaken throughout the reporting period and the compliance to each standard will be updated accordingly. The service is currently on track will 9 of the standards with only 1 standard currently at risk. This relates to standard 7 and MNVP attendance at Perinatal Mortality Review Tool meetings (PMRT). The capacity for the MNVP lead to attend is limited due to the commissioning agreement with the LMNS.	1. Delivery of the Maternity Neonatal Improvement plan and Trust Single Improvement plan.	1. Continue to monitor MIS standards via the maternity and Neonatal Safety Report to safety and quality committee. 2. ICB Local Maternity Neonatal System validation of CNST delivery of standards.
Perinatal - Number of Stillbirths	The stillbirth rate continues to be monitored monthly by the service. There were no stillbirths in May and one in June 2025. This was a stillbirth at 39 weeks which was identified when the mother attended for elective caesarean section. An initial review has been undertaken, and the case has been referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) and a reviewed using the Perinatal Mortality Review Tool (PMRT) is planned. The 12-month average mean (May 24-April 25) still birth rate is 2.8 per 1000 and 3.2 per 1000 cumulatively since March 2023. These are both lower when compared against the national average of 3.9 per 1000.	1. Implementation of the 10 CNST maternity neonatal safety standards.	1. Monthly dashboard analysis shared via the maternity and neonatal safety report to safety and quality committee. 2. Peer comparison data included within the reporting 3. National embrace reporting provides overview of national themes to ensure learning is understood nationally. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards.

Productivity - Assurance



Latest YTD Actual (,000s)
-12,471
Latest YTD Target (,000s)
-7,012
March 26 YTD Target (,000s)
-

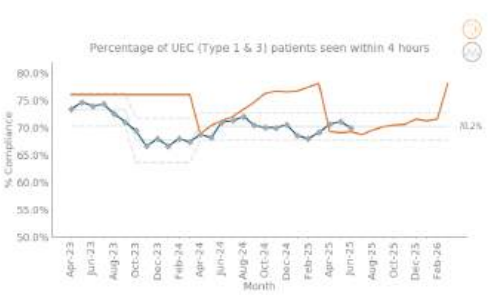


Latest YTD Actual (,000s)
3,582
Latest YTD Target (,000s)
9,498
March 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The Trust submitted the final financial plan to NHSE at the end of April. For 2025/26 the Trust has a break-even plan which is reliant on a recurrent waste reduction programme of £60m and non-recurrent deficit support funding of £30m. At the end of June 2025 the Trust has a deficit of £12.5m against a planned deficit of £7.0m. The adverse variance to plan of £5.5m is mainly as a consequence of the shortfall in delivery of the Waste Reduction Programme. At the time of setting the plan the Trust had not identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy. The shortfall in efficiency programme to the end of June was £5.9m. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust has appointed a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE as part of the recovery support programme. A focus on grip and control activities continues. The Trust has commissioned further external support to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to mitigate shortfalls in the efficiency target as schemes move through development and implementation stages.	Turnaround Director Working with ICB on UEC Pathway I&E Interventions and control measures Mandated national support from PWC
WRP schemes delivery	The Trust's objective to reach financial balance on a recurrent basis by the end of the three-year period (2026-27) will require delivery of an ambitious and very challenging financial recovery plan. The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of June the Trust has delivered £10.2m of the £60m target (17%). The delivery in month was £2.1m against a plan of £3.6m. The Trust has identified schemes and opportunities to the value of £60m however the phasing is different to the financial plan with shortfalls in the first 6 months being offset with gains in the final 6months of the year.	The Trust has a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. Support has been commissioned for procurement, contract management and other specific workstreams. The Trust is building up its own project management office structure to have a sustainable solution moving forward.	Turnaround Director Waste reduction programme board chaired by CEO External support for procurement and other specific workstreams. Implementation of PMO

Performance - UEC Assurance

Latest
90.1%
Variance Type
Normal variation - no recent change
Mar-26 Target
100%
Target Achievement
Could both pass or fail target within expected variation

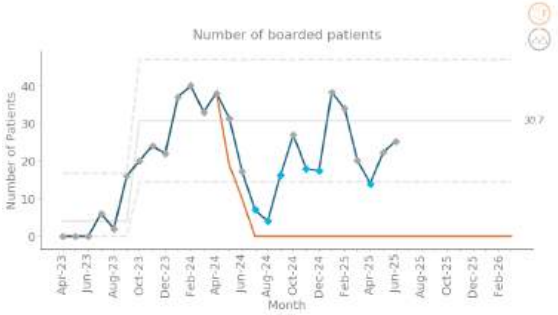


Latest
69.92%
Variance Type
Normal variation - no recent change
Mar-26 Target
78.02%
Target Achievement
Will consistently fail target within expected variation

Latest
10.96%
Variance Type
Normal variation - no recent change
Mar-26 Target
8.20%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In June 25 431 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a decrease of 47 from last month. 222 patients waited over 60 minute to be handed over from NWAS to the Trust in June 25, a decrease of 91 compared to May. Over 90% of patients were handed over within 60 minutes, an improvement of 4% compared to May 25.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways. This accompanied with the improvement actions focusing on reducing LOS and NMC2R which will reduce ED Overcrowding and support more timely handover and attendance and admission avoidance actions is aimed to see improvements.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for June 25 indicates that the Trust is below the national performance position of 92.8% for 60 minute handovers and below the NW performance position of 93%.
Percentage of UEC (Type 1 & 3) patients seen within 4 hours	Performance against the national 4 hour access standard deteriorated slightly in June 2025. The performance reduction was -1.1% compared to May. June experienced a daily attend rate consistent with May.	The UEC Improvement programme is focusing on measures to reduce the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly. SDEC activity has been maintained and exceeded the target in June (40.7%).	The average time to triage in June reduced to 16 minutes with time to treatment increasing to 162 minutes. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for June 25 of 75.5% and was ranked 16th out of Trusts in the NW Region for June 25.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted) in ED increased in June to 11%, an increase of 0.44% compared to May. This follows a period of deteriorating performance to Jan 2025. The position shows normal variation and will consistently fail the year end target.	The UEC improvement programme is focusing on reducing length of stay via improving board and ward round standards and driving down the days patients spend in hospital when they no longer require inpatient care.	Overall Bed Occupancy was at 92.4%%, with a range from 92% - 97% in the last 12 months. The level of boarded patients increased in June with an average of 25 patients per day. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

Performance - UEC Assurance



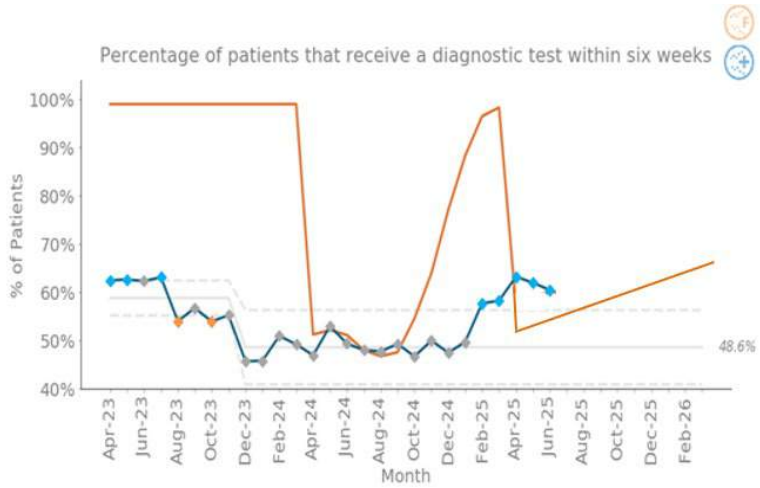
Latest
25
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation

Latest
92.37%
Variance Type
Normal variation - no recent change
Mar-26 Target
90.00%
Target Achievement
Will consistently fail target within expected variation

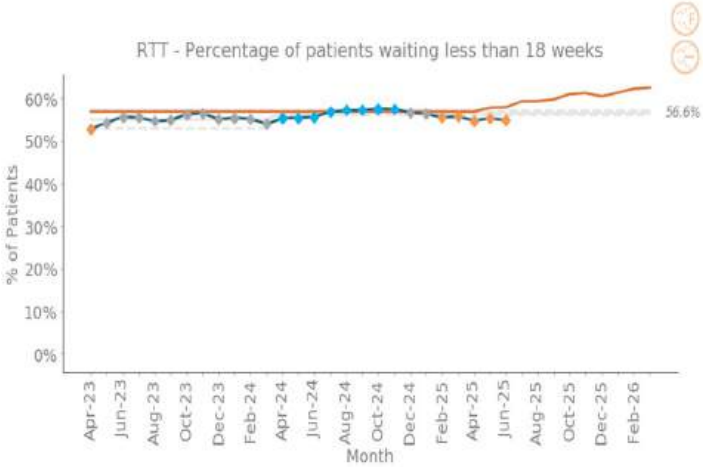
Latest
10.9%
Variance Type
Normal variation - no recent change
Mar 26 Target
4.7%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 25 patients were boarded each day across both sites during June with 758 associated bed days. This is a deterioration compared with the May position. These are predominantly medical patients requiring admission to an acute medical ward. The position shows normal variance and will consistently fail the target within expected variation.	A focus on maximising use of the discharge lounge to reduce the need for boarding. The Medical Division has re-introduced Continuous Flow Model WC 17th March 2025.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed Occupancy	The position shows a reduced occupancy rate for June 25 of 92.4%. This is the 4th consecutive month of reduced occupancy levels. The data shows normal variation and will consistently fail the target.	The 24/25 UEC Improvement plan continue to be tracked against its ambitions to reduce avoidable admissions and reduce LOS. A significant change to the 25/26 UEC plan has been proposed and supported by the L&SC ICB and Central Lancashire UEC Delivery Board. Plans to further scope and mobilise the 25/26 programme is underway at pace. LTH has closed a 24 bedded ward in line with its Financial Recovery Plan at the end of Feb 25.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Reduce NMC2R	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased in June (10.9% = daily average of 92 patients). Compared to the May position this is a decrease of 3.2%. The data shows normal variance and is below the monthly target.	A Multi Agency Discharge Event (MADE) was held WC 24 Feb 25 and identified key themes which will support the reduction in discharge delays. Immediate actions are being undertaken supported by a 25/26 Days Kept Away from Home transformation programme. This will seek to significantly reduce the number and days patients spend away from home without clinical rationale. Additional metrics in relation to Days Kept Away From Home are currently being developed.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance



Latest
60.4%
Variance Type
Recent positive pattern in the data
Mar 26 Target
65.0%
Target Achievement
Will consistently fail the target within expected variation

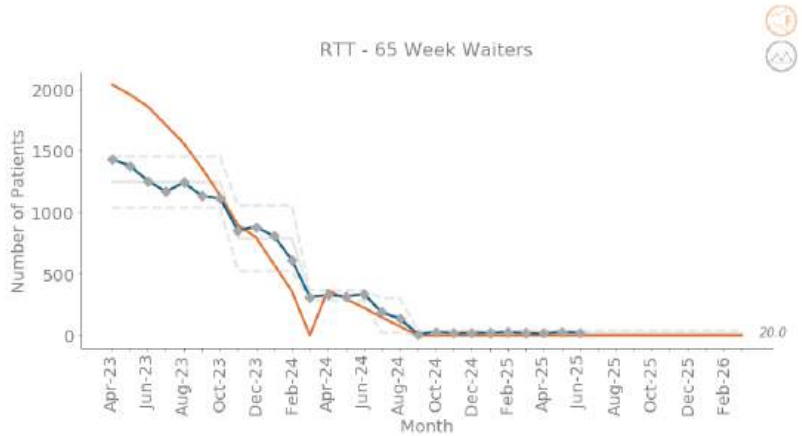


Latest
54.9%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
62.5%
Target Achievement
Will consistently fail the target within expected variation

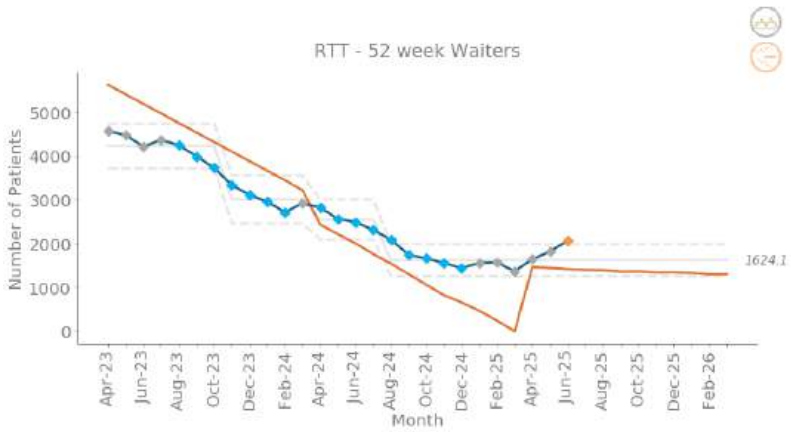
Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostics under 6 week performance was 60.4% in June compared to 62.0% in May, a 1.6% deterioration on the May position, but above trajectory. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows a recent positive pattern in the data but may consistently fail the target.	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. A rapid improvement week, held WC 13/01/25 to support productivity improvements and reduce process barriers to support improved utilisation of the available endoscopy capacity. Actions and progress are being tracked weekly in a COO led PTL management meeting and monthly within the Diagnostic Improvement Group. Performance improvements have been achieved in scopes, Audiology and Sleep Studies during June 25.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (May 25) indicates that LTH is the worst performing NHS Trust in the NW region, worst performing Trust in the ICB and significantly below the national average of 78%.
Percentage of patients waiting less than 18 weeks	The proportion of patients waiting less than 18 weeks on an RTT pathway has shown a consistent position throughout 2024/25. The Operational Plan 2025/26 year end target has been set at 65%. The June 25 position of 54.9% showed a slight deterioration compared to May 25 Analysis suggests recent concerning pattern in the data and that the target may be consistently failed.	Performance is monitored at Divisional level via the Elective Performance Review Group where Issues and risks.	Comparison to the latest national performance position (May 25) indicates that the Trust is below the national position of 61.1% waiting under 18 weeks'

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



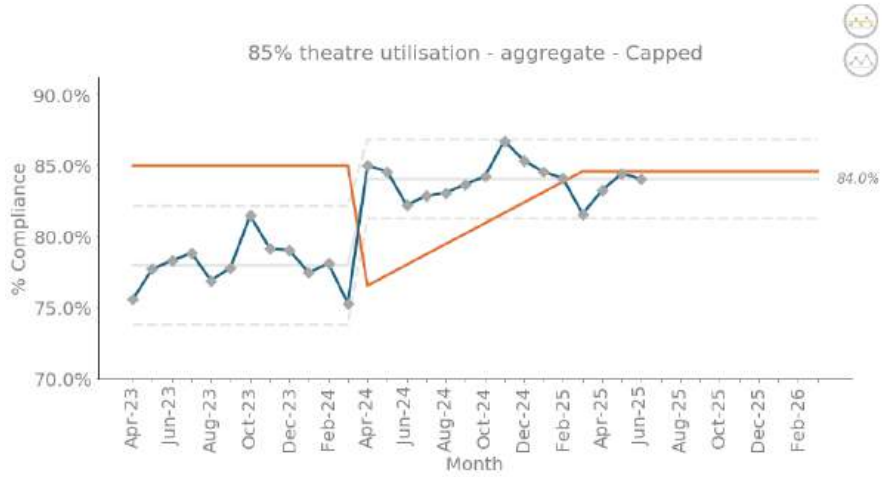
Latest
22
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail target within expected variation



Latest
2068
Variance Type
Recent concerning pattern in the data
Mar 26 Target
1304
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
RTT - 65 Week Waiters	The over 65 week waiters position decreased in June to 22 from 27 in May 25. This is due to capacity shortfalls, equipment issues and on the day patient cancellations. There data shows normal variation, however analysis would suggest that the target may be consistently failed.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is being concluded in line with the 25/26 annual planning process. Comparison to the latest NW region position indicates that the Trust is currently 14th out of all acute and specialist trusts and 8th out of acute Trusts in terms of the number in the 65 week waiter cohort.
RTT - 52 week Waiters	The over 52 week waiter position in June was 2068, an increase of 245 compared to the May position. There is recent concerning pattern in the data, however the target could be passed or failed within normal variation.	Capacity & Demand modelling is to be undertaken for all specialities and sub specialities. Focus on DNA reduction, PIFU and theatre utilisation is ongoing to maximise capacity.	Local monitoring of all speciality RTT clock stop/performance is undertaken via fortnightly Performance Recovery Group Comparison to the latest national performance position (May 25) indicates that the Trust is slightly above the national picture which is 2.7% waiting over 52 weeks.

Performance - Theatre Utilisation

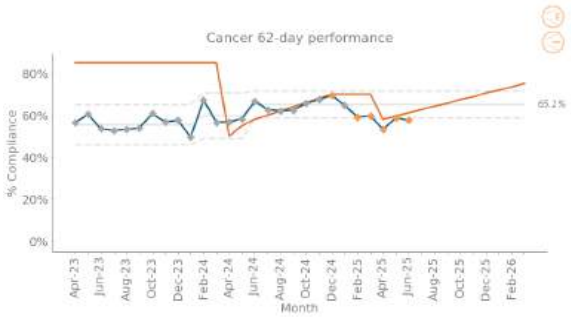


Latest
84.0%
Variance Type
Normal variation - no recent change
Mar 26 Target
84.6%
Target Achievement
Could both pass or fail target within expected variation

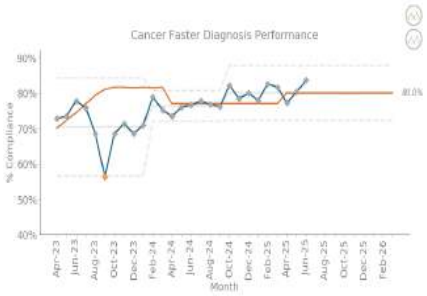
Metric	Summary	Action	Assurance
85% theatre utilisation - aggregate - Capped	Performance throughout 24/25 has been positive with regards theatre utilisation however a deterioration has been noted in March and April due to pressures within the HSDU provision.	An assessment of process within HSDU has been undertaken by the Continuous Improvement team with benchmarking via other similar units. Further improvement plans are in development with close monitoring of performance metrics.	Improvements in theatre utilisation are monitored through the Divisional Improvement Forums with a focus on capped and uncapped utilisation rates, levels of cancellations, late starts and early finishes. Theatre data is also submitted to Model Health for national analysis.

Performance - Cancer Assurance

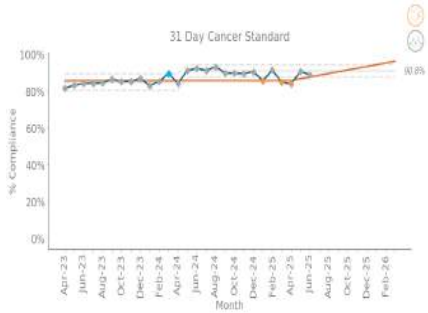
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
57.5%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
75.1%
Target Achievement
Will consistently fail target within expected variation



Latest
83.6%
Variance Type
Normal variation - no recent change
Mar 26 Target
80%
Target Achievement
Could both pass or fail target within expected variation



Latest
88.6%
Variance Type
Normal variation - no recent change
Mar 26 Target
96.0%
Target Achievement
Will consistently fail target within expected variation

JUNE POSITIONS ARE UNVALIDATED AND THEREFORE SUBJECT TO CHANGE

Metric	Summary	Action	Assurance
Cancer 62-day performance	Performance to the end of June 25 (**currently unvalidated and expected to meet the target**) is below last month, and below the monthly operational plan target of 58%. Analysis shows a recent concerning pattern in the data and will consistently fail the target.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 67.8% (May 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
Cancer Faster Diagnosis Performance	Performance to the end of June 25 (**currently unvalidated**) is above last month, and above the monthly operational plan target of 80%. Analysis shows normal variation in the data and could both pass and fail the target.		The Trust is currently above the latest national average performance of 74.8% (May 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
31 Day Cancer Standard	Performance to the end of June 25 (**currently unvalidated and expected to meet the target**) is below last month, and above the monthly operational plan target of 86%, however is expected to achieve the target once validation is complete. Analysis shows normal variation in the data and will consistently fail the target.		The Trust is currently below the latest national average performance of 91% (May 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group

11.2 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | J Schorah | 11.45am

Item for assurance

REFERENCES

Only PDFs are attached

11.2 - Chair's report - FPC - 27 May & 24 June 2025.pdf

Chair's Report to Board		
Chair: J Schorah	Committee: Finance and Performance Committee	
Date(s): 27 May & 24 June 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	None

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- There was a significant interdependency between WRP delivery and performance, especially in relation to workforce and variable pay. The implications for cash flow were material, with Q2 identified as a pressure point. Although the Trust was currently on plan, the position was delicate.
- While showing progress, remained fragile. The in-year delivery gap was narrowing but still subject to risk, particularly given the steep delivery trajectory required and the Trust's underperformance in the previous year.
- A significant update was noted regarding principal risk 13, which concerned the cash consequences of the underlying financial position. The risk score had increased due to assumptions around restricted cash support and waste reduction planning, with concerns about cash availability beyond August 2025.
- The importance of maintaining visibility and urgency around the delivery of schemes for the WRP cadence was emphasised, particularly in light of previous lessons where timelines had not been met.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Diagnostic performance (DM01) had improved but was heavily reliant on temporary additional capacity. Without resolution of the income position, performance was projected to fall sharply, potentially back into the 20% range.
- There was a need to improve understanding of the resource implications, particularly administrative capacity, on performance metrics such as DNAs.
- Progress was reported on reducing reliance on PwC. A three-month transition plan had been agreed with the ICB and NHS England, pending final regional approval. This would maintain support through to September while internal PMO capacity was built.

ASSURE

Assurance received; Matters of positive notes

- The Committee noted strong progress in several areas of performance, including urgent and emergency care, diagnostics, and cancer pathways. While challenges remained, the direction of travel was positive and reflected focused operational effort.
- The Single Improvement Plan (SIP) had delivered significant improvement in year one, despite not

achieving all original metrics. The Committee was assured that year two was now aligned with strategic priorities and focused on actions with measurable impact.

- Procurement governance and performance reporting had improved, with new KPIs and oversight structures in place. While accountability structures were still evolving, the Committee was assured by the direction of travel.
- The executive team continued to monitor the risks associated with delivering within current financial constraints, particularly regarding RTT and diagnostics performance.

Finance and Performance Committee

27 May 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 22nd April 2025	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.10pm	✓	Decision	S Regan
7.	OPERATIONAL PERFORMANCE				
7.1	Performance Assurance Progress Report [including Finney House Update]	1.25pm	✓	Assurance	K Foster-Greenwood
8.	FINANCIAL PERFORMANCE				
8.1	Month 1 Financial Position inc. costing, costing transformation and patient-level costing and WRP	1.40pm	✓	Assurance	C Carter
8.2	IAG Update	2.00pm	Verbal	Assurance	C Carter
8.3	One LSC Procurement update (incorporating supplier scores)	2.15pm	✓	Assurance	J Collins
9.	STRATEGY & PLANNING				
9.1	Planning Controls inc. SIP progress & external dependencies	2.35pm	✓	Assurance	A Brotherton
9.2	Annual plan, forward plan preparation & 3-year trajectory (Year 1 Annual Plan)	2.50pm	✓	Assurance	I Ward
9.3	Green Plan	3.05pm	✓	Decision	N Pease
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure Board	3.20pm	Verbal	Information	J Schorah
10.2	Reflections on the meeting	3.25pm	Verbal	Information	J Schorah

№	Item	Time	Encl.	Purpose	Presenter
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	Chair's Reports/Minutes: (a) SIRO/AIO Working Group (b) CSESC Minutes (c) LHS Ltd Minutes		 ✓ ✓ ✓		
11.3	Date, time, and venue of next meeting: *24 June 2025, 1.00pm, Microsoft Teams*	3.30pm	Verbal	Discussion	J Schorah

Finance and Performance Committee

24 June 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 27 May 2025	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.15pm	✓	Decision	S Regan
7.	FINANCIAL PERFORMANCE				
7.1	M2 finance update including WRP and IAG	1.25pm	✓	Assurance	C Carter
8.	STRATEGY & PLANNING				
8.1	Planning Controls inc. SIP progress & external dependencies	2.10pm	✓	Assurance	A Brotherton
8.2	Annual plan, forward plan preparation & 3-year trajectory (Head Contract update)	2.25pm	✓	Assurance	I Ward
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	2.55pm	✓	Assurance	K Foster-Greenwood
10.	GOVERNANCE AND COMPLIANCE				
10.1	Cyber Security Update	3.20pm	✓	Assurance	S Keyton
10.2	Items to Alert, Advise or Assure the Board	3.30pm	Verbal	Information	J Schorah
10.3	Reflections on the meeting	3.40pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		

№	Item	Time	Encl.	Purpose	Presenter
11.2	Chair's Reports/Minutes: (a) Information Governance & Records – no meeting (b) CSEC Minutes (c) LHS Ltd Minutes – no meeting		✓ ✓		
11.3	Date, time, and venue of next meeting: *22 July 2025, 1.00pm, Microsoft Teams*	3.45pm	Verbal	Discussion	J Schorah

12. RISK, GOVERNANCE AND COMPLIANCE

12.1 AUDIT COMMITTEE CHAIR'S REPORT

Other | T Wheeler | 11.55am

For Assurance

REFERENCES

Only PDFs are attached

12.1 - Audit Chair's Report - 24 June 2025.pdf

Chair's Report to Board		
Chair: T Wheeler	**Committee: Audit**	
Date(s): 24 June 2025	**Agenda attached for information**	✓

Strategic Risks	trend	Items Recommended for approval
N/A		**None**

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	• **Annual Report and Accounts:** The annual report and accounts for the year 24/25 had been reviewed and were ready for final approval. They would be signed off electronically and submitted to NHS England by the deadline.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	• **Health and Safety Review:** The internal audit report on health and safety has been given limited assurance. There are concerns about the implementation and operational delivery of health and safety measures. An action plan is in place to address these issues, and progress will be monitored closely. • **Financial Sustainability:** The external audit identified a significant weakness in financial sustainability arrangements earlier in the year. Improvements have been made in the latter part of the year, but maintaining these improvements is crucial. • **Procurement Process for External Auditors:** The Board should be informed that the procurement process for external auditors will follow a mini competition rather than a full tender, as advised by the procurement team. This approach is expected to be more efficient while still ensuring due process.
ASSURE **Assurance received; Matters of positive note.**	• None

Audit Committee

24 June 2025 | 9.30am-11.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9.30am	Verbal	Information	Chair
2.	Apologies for absence	9.31am	Verbal	Information	Chair
3.	Declaration of interests	9.32am	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 17 April 2025	9.33am	✓	Decision	Chair
5.	Matters arising and action log	9.35am	✓	Decision	Chair
6. INTERNAL AUDIT					
6.1	**MIAA Final Reports:** a) Data Quality, Waiting List Management (Diagnostics) – (Moderate) b) Mandatory Training – (Substantial) c) Patient Safety Incident Response Framework – (Substantial) d) Health & Safety Governance – (Limited)	9.40am	✓	Assurance	MIAA
6.2	Internal audit progress report	10.00am	✓	Assurance	MIAA
7. ANNUAL REPORT AND ACCOUNTS 2024-25					
7.1	Head of Internal Audit Opinion 2024-25	10.05am	✓	Assurance	MIAA
7.2	(a) Draft ISA 260 (b) External audit annual report 2024-25	10.15am	✓	Assurance	KPMG
7.3	Draft financial accounts 2024-25 including (a) List of movements from circulated accounts and (b) Draft audited annual accounts	10.30am	✓	Assurance	Assistant Director of Financial Services
7.4	Management representation letter: financial accounts 2024-25	10.40am	✓	Decision	KPMG
7.5	Draft Annual Report	10.45am	✓	Assurance	Director of Corporate Affairs
7.6	Review of draft Annual Governance Statement (see pages 91 to 108 in A/R)	10.55am	✓	Assurance	Director of Corporate Affairs

№	Item	Time	Encl.	Purpose	Presenter
7.7	Recommendation of 2024-25 Annual Report and Accounts to Board of Directors	11.00am	Verbal	Decision	Chair
8. GOVERNANCE					
8.1	IG Annual Assurance Report (Compliance with Data Protection and Security Toolkit)	11:05am	✓	Assurance and Approval	Director of Corporate Affairs
8.2	Losses and Special Payments	11:10am	✓	Assurance	Assistant Director of Financial Services
8.3	Process for the Appointment of External Auditors	11.15am	✓	Assurance	Chief Procurement Officer
8.4	Items to alert, assure and advise to Board or refer to other committees	11.20am	Verbal	Discussion	Chair
8.5	Reflections on the meeting	11.22am	Verbal	Discussion	Chair
8.6	L & SC Audit Chairs' Briefing	11.25am	Verbal	Information	Chair
9. ITEMS FOR INFORMATION					
9.1	Strategic Risk Report		✓		
9.2	NHS FT Code of Governance compliance		✓		
9.3	Final Internal Audit Plan 25/26		✓		
9.4	MIAA Insight – Global Internal Audit Standards (UK Public Sector)		✓		
9.5	MIAA TIAN NHS Monthly Insight Report		✓		
9.6	Risk Management Strategy – Yr 1 Update		✓		
9.7	Anti-Fraud Progress Report		✓		
9.8	Date, time and venue of next meeting: *18 September 2025, 10.30am, Microsoft Teams*	11.30am	Verbal	Information	Chair

12.2 CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT

Other | T Ballard | 12.05pm

Item for Assurance

REFERENCES

Only PDFs are attached

12.2 - Charitable Funds Committee Chairs Report - 17 June 2025 - approved.pdf

Chair's Report to Board		
Chair: Tim Ballard	**Committee: Charitable Funds Committee**	
Date(s):17 June 2025	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
N/A		**None**

ALERT **Areas of concern;**	NONE
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	NONE
ASSURE **Assurance received; Matters of positive note.**	• The Committee noted the positive nature of all elements discussed, including examples of high-level grants awarded. • The Committee noted its satisfaction from the investment strategy review presented by Brewin Dolphin.

Charitable Funds Committee

17 June 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	T Ballard
2.	Apologies for absence	1.01pm	Verbal	Information	T Ballard
3.	Declaration of interests	1.02pm	Verbal	Information	T Ballard
4.	Minutes of the previous meeting held on 18 March 2025	1.03pm	✓	Decision	T Ballard
5.	a) Action log & Matters Arising	1.04pm	✓	Decision	T Ballard /D Hill
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat	1.05pm	✓	Assurance	D Hill
6.2	Rosemere Charity update inc. funding requests: a) Rosemere Charity Update b) Funding requests: I. RCF042-24/25 - Bowland House Accommodation for Cancer Patients - 2025-26 - £40,000 II. RCF001-25/26 - Chemotherapy Staff room and Chorley Chemo reconfiguration - £57,372	1.15pm	✓	Decision	D Hill
6.3	Investment strategy and investment review including ESG annual performance report	1.30pm	✓	Decision	Brewin Dolphin/B Patel
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	1.40pm	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items to alert/advise/assure the Board	1.50pm	Verbal	Information	T Ballard
8.2	Reflections on the meeting	1.55pm	Verbal	Information	T Ballard
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		

№	Item	Time	Encl.	Purpose	Presenter
	Date, time and venue of next meeting: *16 September 2025, 1.00pm, MS Teams*	2.00pm	Verbal	Information	T Ballard

12.3 EPRR CORE STANDARDS ASSURANCE

Decision Item | K Foster-Greenwood | 12.15pm

REFERENCES

Only PDFs are attached

12.3 - EPRR Core Standards Annual Assurance 2025-2026.pdf

Board of Directors Report

Emergency Preparedness, Resilience & Response (EPRR) Core Standards Annual Assurance 2025-2026

Report to:	Board of Directors	**Date:**	7 August 2025
Report of:	Chief Operating Officer (accountable Emergency Officer)	**Prepared by:**	S Hughes
Part I	√	**Part II**	

Purpose of Report

For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide assurance to the Trust Board around the Trust's Emergency Preparedness Resilience and Response (EPRR) self-assessment annual review and associated work plan. Following this year's review, the Trust will be making an overall submission of **Substantial Compliance**, as defined in the NHS Core Standards terminology. This rating evidences the ongoing improvements in the Trust's EPRR arrangements and further supports continued progression of the core standards, towards achieving improved compliance, in all areas.

This report details the annual self-assessment conducted for the period 2025-2026. A summary of the report highlights:

- **EPRR Governance and Accountability:** The organisation has an appointed Accountable Emergency Officer (AEO) responsible for EPRR, supported by board-level oversight. Annual reporting, work programmes, and resource allocation ensure compliance with EPRR standards.
- **Risk Assessment and Management:** Processes are in place to assess risks to the population, including community and national risk registers. Mechanisms for reporting, monitoring, and escalating risks internally and externally are robust.
- **Incident Response and Preparedness:** The organisation has arrangements to respond to critical incidents, adverse weather, infectious disease outbreaks, pandemics, mass casualties, and evacuation scenarios. Plans are developed collaboratively with stakeholders and tested regularly.
- **Business Continuity Planning:** Business continuity plans address disruptions to people, premises, IT, and suppliers. The organisation conducts impact analyses, audits, and exercises to ensure resilience, aligning with ISO 22301 standards.
- **Hazmat/CBRN Preparedness:** The organisation maintains Hazmat/CBRN plans, training, and equipment, including wet decontamination capabilities and PPE. Regular maintenance, risk assessments, and staff training ensure readiness for chemical, biological, radiological, and nuclear incidents.

Of the 62 core standards, the self-assessment rated 58 standards as fully compliant with supporting evidence and 4 standards assessed as being partially compliant. Mitigating actions are in place.

Of the 4 standards that are not 'Fully met' the associated actions are as follows:

EPRR Resource: The Trust has approved the establishment of an additional Band 6 EPRR Officer. The post is under recruitment. It is anticipated that this post will be filled by October 2025 which will make the standard fully compliant.

Warning & Informing: The Trust has robust arrangements in place to support timely and structured communication via media and social media. However, two key policies required for ICB submission are overdue for review. At the time of reporting these have been reviewed by the Comms team and once uploaded to Heritage, this standard will be upgraded to fully compliant, prior to final submission to the ICB.

Data Protection & Security Toolkit: The IT department submitted all required evidence for the 2024–25 Data Protection and Security Toolkit by the national June 2025 deadline. The current status is 'standards not met'. An improvement plan has been submitted and will be reviewed by the NHSE in July. If accepted, the status will be upgraded to 'approaching standards' and the core standard will be deemed fully compliant prior to final submission to the ICB.

Business Continuity: The Trust has developed a supplier audit template to assess business continuity arrangements among commissioned providers. While supplier BCP requirements are referenced in the Trust's Business Continuity Policy, current evidence of compliance remains limited, particularly where contracts are managed via national frameworks, making Trust-level assurance difficult.

Both the ICB and NHS England confirm that individual Trusts are responsible for obtaining and retaining this assurance. EPRR will continue to prompt BCP owners to complete supplier audits for directly procured services, and the Trust must also extend this process to Trustwide contracts.

It is recommended that:

I. The Board formally acknowledge the Trust's submission of Substantial Compliance for the EPRR Core Standards for 2025-2026, as detailed in Appendix 1. Recognising the approval granted by both the Accountable Emergency Officer and the Finance and Performance Committee, reinforcing the Trust's dedication to maintaining high standards of emergency preparedness.

II. The Trust publicly states its readiness and preparedness activities in its annual reports, in accordance with its annual regulatory reporting requirements and in alignment with Core Standard 35.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒

To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☒

Previous consideration
Finance & Performance Committee, 22 July 2025; approved Trust Management Board, 16 July 2025; approved

1. **Background/Context**

   The overall aim of the EPRR core standards annual assurance process is to assess the preparedness of the NHS (both commissioners and providers) against common NHS EPRR Core Standards, to formally assure that NHS England and the NHS in England is prepared to respond to an emergency whilst maintaining services to patients. This report contains details of Lancashire Teaching Hospitals NHS Foundation Trusts' EPRR annual self-assessment submission, for approval.

2. **Compliance**

   Emergency Preparedness, Resilience and Response (EPRR) Assurance 2025-26

   Lancashire Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR.

   Following self-assessment, and in line with the definitions of compliance, the organisation declares itself as demonstrating the following level of compliance against the 2025-26 standards: **Substantial Compliance**.

   Statement of Compliance

   Appendix 1: Statement of compliance details the Trusts 2025-2026 overall submission of **Substantial Compliance** for the EPRR Core Standards Annual Self-assessment; this submission was approved and signed off by the Accountable Emergency Officer on 25/07/2025.

   LTHTr Core Standards Self-Assessment

   The self-assessment against the relevant core standards, identifying the level of compliance for each standard, including supporting evidence can be found in **Appendix 2: LTHTr Core Standards for EPRR 2025**.

   The above level of compliance with the EPRR Core Standards will be confirmed by the Trusts Finance and Performance Committee, for approval from the Trust Board to submit the annual assurance return.

The overall position of the core standards compliance for 2025/26 is:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	58	4	0

Of the 4 standards that are not 'Fully met' the associated actions are as follows:

EPRR Resource: The Trust has approved the establishment of an additional Band 6 EPRR Officer. The post is under recruitment. It is anticipated that this post will be filled by October 2025 which will make the standard fully compliant.

Warning & Informing: The Trust has robust arrangements in place to support timely and structured communication via media and social media. However, two key policies required for ICB submission are overdue for review. Once updated, this core standard will be revised to reflect full compliance. The team responsible has been notified.

Data Protection & Security Toolkit: The IT department submitted all required evidence for the 2024–25 Data Protection and Security Toolkit by the national June 2025 deadline. The current status is 'standards not met'. An improvement plan has been submitted and will be reviewed by the NHSE in July. If accepted, the status will be upgraded to 'approaching standards' and the core standard will be fully met.

Business Continuity: The Trust has developed a supplier audit template to assess business continuity arrangements among commissioned providers. While supplier BCP requirements are referenced in the Trust's Business Continuity Policy, current evidence of compliance remains limited, particularly where contracts are managed via national frameworks, making Trust-level assurance difficult.

Both the ICB and NHS England confirm that individual Trusts are responsible for obtaining and retaining this assurance. EPRR will continue to prompt BCP owners to complete supplier audits for directly procured services, and the Trust must also extend this process to Trustwide contracts.

Deep Dive
Typically, each year as part of the annual process, a deep dive is conducted to gain additional insight in a specific area. NHS England will not, however, be conducting a deep dive this year.

ICB Assurance Review
As part of the assurance process, the ICB will conduct an in-person review at RPH on 9 and 10 September, working closely with the EPRR Manager. All core standards will be examined with supporting evidence to validate the Trust's self-assessment. The goal is to ensure each rating is fully justified and provides assurance to both the ICB and NHSE.

In addition, the ICB may conduct a dip sample of 5–6 core standards to explore areas of concern or highlight good practice. We are currently awaiting confirmation on whether this will take place.

EPRR Annual Report
The attached **Appendix 3: EPRR Annual Report,** details EPRR activity which has taken place over the last year.

3. **Financial implications**
   'None'

4. **Legal implications**
   'None'

5. **Risks**
   'None'

6. **Impact on stakeholders**
   Not applicable

7. **Recommendations**

It is recommended that:

I. The Board formally acknowledge the Trust's submission of Substantial Compliance for the EPRR Core Standards for 2025-2026, as detailed in Appendix 1. Recognising the approval granted by both the Accountable Emergency Officer and the Finance and Performance Committee, reinforcing the Trust's dedication to maintaining high standards of emergency preparedness.

II. The Trust publicly states its readiness and preparedness activities in its annual reports, in accordance with its annual regulatory reporting requirements and in alignment with Core Standard 35.

Lancashire & South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

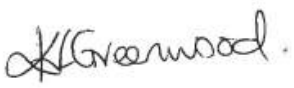
Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, LTHTr will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.



Signed by the organisation's Accountable Emergency Officer

25/07/2025

Date signed

07/08/2025	2025/2026	2026
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Please select type of organisation: **Acute Providers**
Click button to format the workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	58	4	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	The Chief Operating Officer is the Trust's appointed Accountable Emergency Officer (AEO) Katie Foster-Greenwood, with the Deputy Chief Operating Officer serving as their delegate when necessary. The Executive Team Portfolio includes EPRR and Business Continuity under the Chief Operating Officer's responsibilities. The EPRR Policy outlines the specific duties of the AEO. **EPRR Policy**	Fully compliant		
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust has an EPRR Policy that designates the Chief Operating Officer as the Accountable Emergency Officer, responsible for: - Ensuring the Trust has a designated Emergency Planning Officer (EPRR Manager) in accordance with good practice. - Providing the Emergency Planning Officer (EPRR Manager) with the necessary resources, funds, and ensuring all staff are appropriately trained for their roles, with access to an EPRR exercise and training program. - Collaborating with the Emergency Planning Officer (EPRR Manager) to develop and maintain adequate and appropriate Emergency Preparedness and Business Continuity Management arrangements, including proper procedures for managing emergency incidents requiring Trust-level command and control. The EPRR Policy is available via the Trust intranet and Heritage document library. The EPRR Policy was last reviewed in February 2025. **EPRR Policy**	Fully compliant		
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	An EPRR annual summary report, including a statement of compliance and audit, is provided to the Trust Board in the form of the NHSE EPRR Annual Self-Assessment assurance documents and is available in the Board minutes. These reports include updates on training and exercises undertaken in the Trust, summaries of any business continuity, critical, or major incidents experienced, and any lessons identified, if applicable. The Trust's compliance status in relation to the latest NHSE EPRR assurance process is also presented to the Board for oversight and approval. The EPRR Manager is responsible for these board reports. The most recent report was presented to the Board in August 2025. **EPRR Board Report.** **Board Minutes.**	Fully compliant		
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual EPRR work program aligned with current guidance, best practices, and informed by the NHSE EPRR core standards. The EPRR Committee regularly reviews and reports on the work program, especially in light of identified lessons and risks. This reporting process is detailed in the EPRR Policy. **EPRR Workplan & EPRR Policy.**	Fully compliant		
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy outlines the necessary resources and roles needed to execute its functions including a description of EPRR staff. Whilst the EPRR function is currently being fully discharged, it is temporarily being supported by the capacity management administrative team. The Trust recognises that the EPRR team could be strengthened, and this has been re-assessed with the commitment to recruit a Band 6 EPRR Officer to support the EPRR Manager within this financial year. Additionally, the Trust has internal governance processes and organisational structure charts. **EPRR Policy.** **Structure Chart.**	Partially compliant	N.B. While the EPRR function is currently being discharged, the trust is at risk due to its dependence on a single individual in the role. This situation creates a single point of failure, as the entire service relies on one person. Despite the work being completed the trust cannot be considered fully compliant. To ensure robust and resilient EPRR capabilities, additional support and resources are needed to mitigate this risk and ensure continuity in case of absence or turnover of the current individual in the role. A commitment has been made to recruit a Band 6 EPRR Office within this financial year which will go someway to improve the fragility of the EPRR function.	
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The Trust has clearly defined processes for capturing lessons from incidents and exercises. These are reviewed by the EPRR Committee to inform the future development of the Trust's EPRR arrangements. Lessons identified from live incidents or exercises are shared both internally and externally through incident/exercise reports. In accordance with Core Standard 3, any relevant reports are shared annually with the Board. **Core Standards Action Plan.** **EPRR Policy.** **Exercise Action Tracker.** **Plan Action Tracker.**	Fully compliant		
Domain 2 - Duty to risk assess								
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are documented in the Trust's risk register (Datix) and are regularly reviewed by the EPRR Manager. Additionally, these risks are reviewed by the EPRR Committee. Risks on the corporate risk register are reviewed monthly or quarterly as appropriate by the Risk Management Group. **EPRR Risk Register** **EPRR Policy**	Fully compliant		
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust employs a robust method for reporting, monitoring, and escalating risks using the DATIX system. The EPRR Manager reviews risks monthly, and the EPRR Committee conducts quarterly reviews. EPRR risk management is also referenced in the EPRR Policy. **EPRR Risk Register.** **EPRR Policy.** **Trust Risk Management Policy.**	Fully compliant		
Domain 3 - Duty to maintain Plans								
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Plans and arrangements have been developed in collaboration with relevant stakeholders, including emergency services and health partners, aimed at enhancing joint working arrangements and ensuring comprehensive consideration of the entire patient pathway. Updates to plans involve collaboration with surrounding Trusts, ICB, local Police, Fire, and Ambulance services where appropriate. External stakeholders were actively engaged in the exercising and validation of our major incident plan and CBRNe/HazMat plan. Any adjustments resulting from these consultations or exercises are captured in the Amendment History tracker within each respective plan. **Plan Action Tracker.** **Amendment History/Consultation on Plans.** **EPRR Policy Section 5.4.**	Fully compliant		
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has established robust arrangements to define and respond to Critical and Major incidents in accordance with the EPRR Framework. These arrangements are as follows: The Major Incident Response Plan has been fully reviewed and updated within the last year to ensure alignment with the latest national guidance and incorporating feedback from exercises, to enhance preparedness and response capabilities. The updated Major Incident Response Plan has been officially signed off by the appropriate governance bodies within the Trust, ensuring that it has the necessary approval and support at the highest levels. The current version of the Major Incident Response Plan was validated at a live exercise in June 2025. This exercise tested the effectiveness of the plan and the preparedness of the response staff. All colleagues in attendance from Operational, Tactical and Strategic used the Major Incident Response Plan to ensure response staff were well-prepared to execute the plan during actual incidents and ensured that those responsible for implementing the plan are fully aware of their roles and responsibilities during an incident. OPEL levels are monitored four times a day to assess pressures and capacity within the trust. This frequent monitoring allows for timely and appropriate responses to emerging pressures. Local Business Continuity Plans are in place and can be activated if required to maintain essential services during disruptions. These comprehensive arrangements ensure that the organisation is well-prepared to respond to critical and major incidents, maintaining continuity of care and ensuring patient safety. **Major Incident Response Plan.**	Fully compliant		
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has established effective arrangements to respond to adverse weather events in accordance with current guidance and legislation. These arrangements are outlined in the trust's comprehensive Adverse Weather & Health Plan, which includes provisions for both hot and cold weather planning and responses. The plan was reviewed and updated following an Amber Heat Health Alert in June 2025. Outside of responses, annual reviews are also conducted, ensuring that the plan remains current and aligns with the latest guidance from the UK Health Security Agency (UK HSA) and best practices. **Adverse Weather & Health Plan.**	Fully compliant		
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	The Trust has established comprehensive arrangements to respond to infectious disease outbreaks, including a range of diseases and High Consequence Infectious Diseases (HCIDs). The trust has developed a variety of plans and policies to address different infectious agents, ensuring a robust response framework. Specific procedures are in place for the management of Severe Acute Respiratory Infections (SARIs), such as Avian Influenza, MERS-CoV, and SARS. There are also dedicated procedures for managing patients suspected of or infected with Viral Haemorrhagic Fevers (VHFs), including Ebola. All plans and policies are readily accessible to staff via the trust intranet, ensuring that the necessary information and guidance are available when needed. These arrangements ensure that the trust is well-prepared to respond effectively to a wide range of infectious disease outbreaks, safeguarding both staff and patients. **Procedure for Management of Patients suspected of having or infected with VHF** **Procedure for Management of Severe Acute Respiratory Infections** **Outbreak Procedure**	Fully compliant		
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a comprehensive Pandemic Plan to respond to new and emerging pandemics. The plan incorporates the latest national guidance. The plan was included as part of Exercise Hibbert in September 2024 and will be tabletop exercised in full during the 2025/2026 financial year to align with the national exercise programme. **Pandemic Plan.**	Fully compliant		
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependent on the incident.	In line with current guidance and legislation, the organisation has established arrangements to support an incident requiring Countermeasures or Mass Countermeasures deployment. This plan has previously undergone consultation both internally and externally. The Pharmacy Department has a proven track record in incident response, including holding regional stocks of Tamiflu and distributing them as needed during flu outbreaks, responding to Covid 19 vaccine rollout and in response to the MPox outbreak. These measures ensure the Trust is well-prepared to support such deployments effectively. The Countermeasures plan was validated during Exercise Hibbert and the Strategic Commander training in September 2024. **Countermeasures Plan.**	Fully compliant		
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Trust has robust arrangements in place to respond effectively to incidents involving mass casualties. The Major Incident Response Plan was fully reviewed and updated within the last year to ensure alignment with the latest national guidance. It also incorporated feedback from Exercise Arkwright, a mass casualty-focused command and control exercise held in June 2025, further enhancing the Trust's preparedness and response capabilities. The updated Major Incident Response Plan has been formally approved by the appropriate governance bodies within the Trust. Exercise Arkwright tested both the effectiveness of the plan and the preparedness of staff in responding to a mass casualty incident. The exercise used live data and enabled participants to operate in their actual roles within a safe and controlled environment. Staff utilised their action cards from the plan, allowing for real-time validation. These action cards were reviewed during the exercise and subsequently updated to reflect lessons identified. An Emergency Department decant plan is in place to be activated should the ED become overwhelmed during a mass casualty incident. This is supported by established escalation and temporary patient placement procedures. Additionally, the ED has robust processes for safe patient identification, using both the internal Quadramed system and paper-based records, ensuring effective management of unidentified patients during emergencies. Together, these arrangements demonstrate the Trust's strong preparedness to manage mass casualty incidents efficiently and safely. **Major Incident Plan.** **Business Continuity Plans.** **ED Mass Casualty Decant Plan.** **Temporary Placement and Boarding of Patients on Inpatient Wards.**	Fully compliant		
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance and legislation, the organisation has established arrangements for evacuating and sheltering patients, staff, and visitors. The Evacuation and Shelter plan underwent a comprehensive review and consultation process internally and externally in April 2024, incorporating feedback from the NHSE check and challenge and aligning with updated national guidance. These measures ensure the organisation is prepared to effectively evacuate and provide shelter to all individuals during emergencies.The plan underwent its annual review in June 2025. **Evacuation and Shelter Guidance.**	Fully compliant		
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance, regulation, and legislation, the organisation has established arrangements to control access and egress for patients, staff, and visitors during incidents affecting its premises and key assets. The trust maintains an overarching Lockdown/Controlled Access Plan, overseen by the Estates and Facilities division's Security Management Specialist. This plan is regularly administered, reviewed, and tested to ensure readiness. A Lockdown exercise took place in August 2025. These proactive measures ensure the organisation can effectively manage and control access and egress in various incident scenarios, safeguarding the security and safety of all individuals within its premises. **Controlled Access/Lockdown Plan.**	Fully compliant		

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance and legislation, the Trust has established arrangements to effectively respond to and manage "protected individuals," including Very Important Persons (VIPs), high-profile patients, and visitors to the site. The trust operates under an overarching Communications Incident Response plan specifically designed for this purpose, overseen by the Communications Team. Additionally, the LSMS (Local Security Management Specialist) ensures the implementation of robust processes within the trust's security team. These processes are activated upon notification of the presence of a high-profile patient or during high-profile events in the vicinity. Responsibility for managing such incidents is clearly outlined within the organisation's EPRR Policy and Major Incident Plans, ensuring a coordinated and secure environment for all individuals of importance within the trust's premises. **Communications Incident Response Plan.** **Management of Prisoner Patients SOP.** **Prisoners in Hospital Procedure.**	Fully compliant		
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance • in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has actively participated in and comprehends its role within multi-agency arrangements for handling excess deaths and mass fatalities, including mortuary management for rising tide and sudden onset events. The Trust has implemented a robust mortuary surge management plan designed to expand capacity during periods of heightened demand. The Mortuary team is thoroughly acquainted with both internal and external processes and arrangements. They continuously monitor onsite capacity and escalate as necessary. Effective communication is maintained between the EPRR Manager and the Mortuary Team, ensuring all are prepared to raise any concerns promptly. This coordinated approach ensures the organisation is well-prepared to manage and respond to scenarios involving excess deaths and mass fatalities, contributing effectively within the broader multi-agency framework. Since last years core standards return a Mortuary Surge Management Exercise has taken place with lessons identified captured and monitored via the EPRR action tracker. **Mortuary Surge Management Guideline.**	Fully compliant		
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The Trust has robust structures in place to ensure 24/7 receipt and escalation of incident notifications, both internal and external. Notifications can be escalated to executive level when required. The EPRR Policy defines the roles, responsibilities, and processes within the Command and Control structure. Expectations for on-call personnel are clearly outlined in the Policy and further supported by an on-call handbook and SOP, which detail the 24-hour alerting process for managers and key personnel. The on-call rota is accessible via the Trust intranet, and Switchboard can connect staff to the on-call manager at any time. A dedicated incident reporting line is in place within Switchboard, supported by a cascade process to ensure timely communication. The on-call alerting process is tested at least every six months, with additional real-world validation during events such as the mass casualty exercise, Exercise Arkwright (June 2025). Processes are regularly reviewed to ensure continued effectiveness and resilience **EPRR Policy.** **Senior Manager & Exec On Call Handbook.** **Senior Manager & Exec On call SOP.**	Fully compliant		
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The Trust ensures appropriately trained and up-to-date staff are available 24/7 to manage escalations, make decisions, and coordinate key actions. This is supported by the Senior Manager, Executive On-Call, and Trust Operational Officer rota. 90% of on-call personnel have completed NHS England EPRR PHC training, aligned with the National Minimum Occupational Standards. Commanders follow defined decision-making processes set out in the EPRR Policy and are supported by skills-based training and regular exercises simulating escalation scenarios. Familiarity with Joint Emergency Services Interoperability Principles (JESIP) and use of the Joint Decision Model (JDM) underpin their approach. On-call colleagues are clear on consultation and communication protocols, ensuring a collaborative and coordinated response. Maintaining accurate logbooks and decision records is a core expectation. Training frequency is reviewed and updated through the Trust's EPRR Training Needs Analysis (TNA), ensuring ongoing readiness and competence. On-call staff participated in Exercise Arkwright (June 2025), where their decision-making capabilities were actively tested and validated **EPRR Policy.** **Training Needs Analysis.** **Training Records.** **On-Call Rota.** **Senior Manager & Exec On Call Handbook.** **Senior Manager & Exec On call SOP.**	Fully compliant		
Domain 5 - Training and exercising								
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The Trust delivers training in line with a comprehensive Training Needs Analysis (TNA) to ensure staff remain competent in their response roles. This is detailed in the EPRR Policy and supported by the EPRR Training & Exercising document. The TNA clearly defines training requirements for on-call personnel and EPRR staff. A central log, maintained by the EPRR Manager, records attendance at training sessions and exercises, serving as evidence of compliance. The TNA is currently under review, with plans to implement the EPRR training programme via the Blended Learning system. This will improve monitoring and compliance tracking, while offering more accessible and flexible training options for staff. **EPRR Policy.** **Training Needs Analysis.** **Training Records.** **Training & Exercising Guidance.**	Fully compliant		
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	The Trust maintains an exercising and testing programme that meets national requirements and current guidance, ensuring response arrangements are rigorously tested without compromising the safety of participants or patients. Our approach exceeds the minimum standard, with a range of exercises conducted across various scenarios since the last reporting period: - 3 communication exercises - 4 tabletop exercises - 1 command post exercise - Live exercises including a baby abduction scenario, decontamination testing at RPH, and a mass casualty exercise using live data - 9 business continuity exercises - 2 multi-agency training sessions - 2 business continuity awareness workshops Lessons identified from all exercises and training events are systematically captured, informing plan updates and enhancing future preparedness. All exercises are delivered with strict safety controls to ensure no undue risk to participants or patients. Union representatives have been invited to participate in exercises and training sessions, with attendance recorded at several events. **Exercise Schedule.** **Exercise Reports.** **Exercise Action Tracker.** **Incident Debrief Reports.**	Fully compliant		
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	The EPRR Manager oversees a record of training and exercise attendance, ensuring that individuals in key response roles maintain adequate training for their responsibilities, in alignment with Minimum Occupational Standards. A comprehensive Training Needs Analysis (TNA) guides the specific training requirements for on-call staff, ensuring adherence to these standards. Regular reviews of training frequency are conducted based on the EPRR TNA, ensuring that training remains current and relevant. The EPRR Training record accurately reflects and documents the compliance levels for all staff involved in critical response functions. **Training Needs Analysis.** **Training Records.**	Fully compliant		
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	General awareness training, covering the Trusts role and staff responsibilities in an incident, is accessible to all staff. This training includes basic understanding of different declarations, specific actions needed, and plan locations. Mandatory EPRR awareness training is included in the biennial Fire Safety training. On-call staff are informed of their incident roles and plan locations. Incident plans are accessible on the intranet, SharePoint and as hard copies in ICCs. Business Continuity plans are available both on the intranet and locally in hard copy within the Tactical ICC. Action Cards for response roles are in hard copy within ICCs and electronically on the intranet and SharePoint. All Commanders have access to NHSE Principles for Health Command training and various additional training and exercising opportunities take place as required (detailed in Core Standard 23). **Exercise & Training Attendance Records.** **Fire Safety & EPRR Training Figures.** **Board Report.**	Fully compliant		
Domain 6 - Response								
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The Trust has robust arrangements in place to coordinate incident response in line with national guidance. Our Incident Coordination Centres (ICCs) are designed to be flexible and scalable, supporting a range of incident types and operating hours as required. ICCs are established at both main sites, with an identified fallback location to ensure continuity. These operational areas are effectively 'exercised' daily through use and regularly checked by the EPRR team. Equipment is tested routinely and following any significant infrastructure changes to ensure continued functionality and readiness. Documentation to support ICC activation and operation is in place, including the ICC Protocol and the Incident Management Team (IMT) Standard Operating Procedure (SOP). Virtual arrangements are also established to complement physical facilities, enhancing resilience through alternative contingency options. **Incident Coordination Centres Protocol.** **EPRR Policy.** **EPRR - Incident Management Team SOP.**	Fully compliant		
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Response documents are available on the intranet, SharePoint, and in hard copy within the ICC. The EPRR Manager ensures version control is maintained on these documents. Response staff are aware of where to locate plans. Additionally, processes are in place for retaining documents for required periods. **Screenshot of Website.** **SharePoint Screenshot.**	Fully compliant		
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The Trust has a Business Continuity Incident Response Plan and in addition all critical services within the trust have individual business continuity plans to mitigate against various scenarios, such as loss of premises or electricity. Currently, there are 93 BCPs within trust services, each reviewed regularly or upon activation/key changes, and all detailing action cards and escalation processes. These BCPs are accessible electronically on the intranet, with hard copies available locally and in the Major Incident cupboard in the Tactical Incident Coordination Centre. Business continuity plans are reviewed within their divisions, with the process monitored by the EPRR Manager. Concerns are escalated to divisional leads and through the EPRR Committee meeting. A spreadsheet of the BCPs is maintained and manually monitored on a monthly basis by the EPRR Manager. **Screenshot of BCP's in SharePoint/Hard copies in TICC.** **Business Continuity Incident Response Plan.**	Fully compliant		
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The Trust maintains a bank of trained Loggists available 24/7, with contact details accessible in both the TICC and SICC. In their absence, key response staff are aware of the requirement to maintain personal decision logs in line with the organisation's records management policy, handing over to a trained Loggist as soon as practicable. The Major Incident Plan outlines the process for accessing and deploying Loggists and emphasises the importance of maintaining accurate records. Record retention requirements are also detailed within the Plan. Staff action cards include clear prompts to begin personal logs if a Loggist is not immediately available. Loggists and response staff have participated in training and exercises throughout the year, helping to build familiarity and strengthen collaboration during incidents. Log books are readily available in the ICC for immediate use. **Log book.** **Loggists Details.** **Major Incident Plan.** **Training records/TNA.**	Fully compliant		
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependant formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Processes are in place for receiving, completing, authorising, and submitting SitReps. A single point of contact (SPOC) email inbox is monitored daily by the EPRR Manager and Trust Operational Officers. The trust ensures effective communication through various meetings and calls: - Daily System Control Centre Call at 10:30 - Daily bed meetings at 09:00, 13:00, 16:00, and 19:00, administered by the Capacity Management Team The SitRep process is clearly documented, regularly rehearsed, and includes quality assurance and executive sign-off before submission. The SPOC manages circulation, follow-up, and timely submission to ensure accuracy and compliance. The Trust utilises the standard SitRep template and has tested these procedures in both exercises and real-time responses. Most recently, the process was successfully applied during Exercise Arkwright in June 2025. **SitRep Templates.** **Major Incident Plan.**	Fully compliant		
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Key clinical staff have access to the Clinical Guidelines for Major Incident and Mass Casualty events either on the Intranet or a hard copy in the Emergency Department. **Screenshot of Intranet.** **Screenshot of SharePoint.**	Fully compliant		
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Clinical staff have access to the CBRN incident: Clinical management and health protection Guidance either on the Intranet or a hard copy in the Emergency Department. **Screenshot of Intranet.** **Screenshot of SharePoint.**	Fully compliant		
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on-call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The trust has an overarching Communications Incident Response Plan. The communications team is fully aware of the organisation's incident response plan and the procedures for reporting potential incidents. Staff have been trained in incident terminology to ensure accurate declarations in line with the NHS EPRR Framework. Measures are in place to ensure incidents are appropriately described and declared. Contact details for on-call communications staff are available 24/7 within the ICCs or via Switchboard. A media-trained member of staff is available around the clock to support senior leaders during incidents. The communications team maintains a process for logging incoming requests, tracking responses, and ensuring that all information related to incidents is stored effectively. All email correspondence received via the EPRR route is stored within Outlook folders or the Trust SharePoint folders. Records of all inquiries received by the communications team are meticulously kept to provide evidence if required for an inquiry. **Communications Incident Response Plan.** **Adverse Weather Alert Emails.**	Fully compliant		

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Trust has an overarching Communications Incident Response Plan that outlines arrangements for communicating with partners and stakeholders during and after an incident. The Communications Team is responsible for maintaining, reviewing, and regularly exercising this plan to ensure it remains effective. The plan was successfully activated and validated during the mass casualty exercise in June 2025. As part of the exercise, a simulated media request was received, and the Strategic Commander delivered an on-camera statement in response. Hard copies of the Communications Plan, Major Incident Response Plan, and key contact guidelines are available in the ICC. The Communications Team maintains a spreadsheet logging all inbound media requests and teh Trust's responses. They also keep a daily communications log to track media mentions and relevant developments. **Communications Incident Response Plan.** **Major Incident Response Plan.**	Fully compliant		
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The Trust has developed a Communications Incident Response plan to ensure effective communication with stakeholders before, during, and after incidents. This includes patients, staff, partner organisations, stakeholders, and the public. Key elements of the plan include: Established channels to ensure timely communication with staff during incidents, including out-of-hours. Access to critical contacts in partner organisations to warn and inform them about incidents and ensure consistent messaging across different levels. Processes are in place to brief local stakeholders like elected officials and unions during incidents. 24/7 channels are available to communicate effectively with the public. Designated sites within the organisation to display crucial public information during critical times. Plans in place within the Trust to inform patients about appointment changes and to communicate with inpatients and their families during incidents. The Trust publicly acknowledges its preparedness in annual reports, complying with regulatory requirements. The Trust has a trained media spokesperson capable of representing the organisation effectively at all times. Overall, the Communications Incident Response Plan is managed by the Communications Team to maintain readiness for any potential incident. **Communications Incident Response Plan.**	Fully compliant		
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust has a Communications Incident Response Plan in place to support timely and structured communication via traditional and social media during incidents. Key components include: - Media Strategy & Spokespeople: A pool of trained media spokespeople is available to ensure accurate and timely communication with the media. - Social Media Policy & Monitoring: The Communications Team oversees a robust policy for monitoring and engaging on social media, enabling proactive responses to emerging issues. - Social Media Protocols: Clear protocols guide the use of social media to warn and inform the public and stakeholders during incidents, ensuring consistent and appropriate messaging. The plan is maintained by the Communications Team and provides structured guidance to ensure effective communication throughout an incident response. The Trust also has a media enquiries policy and procedure - this policy ensures media enquiries are consistently managed within the organisation to protect and enhance the reputation of LTHTr and to ensure patient confidentiality is safeguarded. **Communications Incident Response Plan.** **Media Enquiries Policy and Procedure.** **Establishing and using work-related social media accounts.**	Partially compliant	Out-of-date plans have been reviewed by Comms, and **once these are available on Heritage in the coming weeks, the compliance rating will change to Fully Compliant prior to our submission to the ICB.**	
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Our AEO (Chief Operating Officer) serves as the Trust's representative at the LHRP meetings. In the event that the AEO is unavailable, the Deputy Chief Operating Officer or one of the Divisional Directors is delegated to attend on their behalf, with the authority to authorise plans and commit resources for the Trust. A representative from the Trust has been in attendance at each of the LHRP meetings held during this assessment period. **EPRR Policy.** **LHRP Minutes/Attendance Record.**	Fully compliant		
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	As a Category 1 responder, the Trust is a member of the Local Resilience Forum (LRF). While formal attendance at LRF meetings and working groups falls under the remit of the Deputy Chief Operating Officer (DCOO), representation is delegated to the Lancashire & South Cumbria ICB. Trust information is shared with the LRF via the ICB, and relevant updates are cascaded back to the Trust's Accountable Emergency Officer (AEO) and EPRR Manager by the ICB EPRR team. Further dissemination is carried out as needed. Information is also shared through LRF General Purposes meeting minutes and updates posted on the LRF Teams channel, to which the EPRR Manager has access.	Fully compliant		

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual aid arrangements are referenced in the Major Incident Plan, enabling us to both access and offer mutual aid as needed. Requests for mutual aid can also be managed through the LSC System Control Centre. Typically, most mutual aid requests currently arrive via the EPRR inbox and are then appropriately cascaded. The acute providers across L&SC have an agreed mutual aid process in place; signed off in June 2025. **Major Incident Plan.** **Draft Mutual Aid Agreement for L&SC.**	Fully compliant		
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	As a Category 1 responder, the Trust will share data in compliance with the Civil Contingencies Act and the EPRR Framework. We utilise Teams Channels, Email, Internet, and Telephone to share appropriate information externally with access to Resilience Direct also a means to manage information sharing via command and control internally during incident responses. The EPRR Policy and Major Incident Plan emphasise the importance of adhering to the UK General Data Protection Regulation (UKGDPR) when sharing information. All Freedom of Information (FOI) requests related to EPRR are managed by the FOI team within the Trust. Over the past 12 months, EPRR has handled numerous FOI requests, reflecting our commitment to transparency and compliance, though this process has been time-consuming. **EPRR Policy.** **Major Incident Plan.** **FOI Policy and Procedure.** **IG & Information Risk Policy.** **Information Security Policy & Procedure.**	Fully compliant		
Domain 9 - Business Continuity								
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The Trust is committed to undertaking business continuity and maintaining a Business Continuity Management System (BCMS) that aligns with ISO standard 22301. The overarching Business Continuity Policy incorporates the BC policy statement and full BCMS commitment. The EPRR Policy and Major Incident Plans further emphasise the Trust's dedication to developing robust business continuity plans, ensuring services can recover and/or be maintained during disruptions. Each business continuity plan has a designated owner responsible for keeping the plan complete, up to date, and regularly reviewed and exercised. Our BCMS and Business Continuity Plan (BCP) template are aligned with the ISO 22301 standard. **EPRR Policy.** **Major Incident Plan.** **Business Continuity Policy.**	Fully compliant		
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The Trust is committed to undertaking business continuity and maintaining a Business Continuity Management System (BCMS) that aligns with ISO standard 22301. The overarching Business Continuity Policy incorporates the full BCMS commitment. Since the last reporting period, further work has been undertaken to fully embed the BCMS across the organisation. This has led to significant improvements in engagement with the process, which is reflected in improved compliance figures for BCP reviews, exercises and audits. **Business Continuity Policy** **Risk Management Policy** **Development and Management of Procedural Documents**	Fully compliant		
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	The Risk Management Strategy talks through the Board Assurance Framework (BAF) which exists within the Trust with the BAF recording organisational wide risks that include risks identified in relation to the business objectives, corporate objectives and the care quality commission Standards. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors via Committees of the Board. The BAF is presented to the Board of Directors meeting on a bi-monthly basis. The frequency at which a Risk is reviewed is determined by the risk score with higher scoring risks requiring more frequent review. The high risks to the organisation are overseen by Senior Leaders, Committees of the Board and Trust Board. Critical Services and interdependencies are listed in the Business Continuity Policy. Business Impact Analysis and Risk Assessment templates are available in the policy for business continuity plan owners to utilise to inform their business continuity plans. Business Continuity plan owners are expected to review their plans annually. Auditing of the BCP's is undertaken by the EPRR Team and feeds into the EPRR Committee meetings. **Business Continuity Policy.** **Risk Management Policy.** **Risk Management Strategy.**	Fully compliant		
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Local Business Continuity Plans (BCPs) are in place across services, outlining how each will respond to, manage, and recover from disruptions affecting staff, data, premises, suppliers, contractors, and IT infrastructure. Plans are aligned with ISO 22301 and the NHS Business Continuity Toolkit. Each BCP is reviewed annually through an internal audit and updated by the plan owner following significant organisational changes, plan activation, or lessons learned from exercises. A central BCP register is maintained by the EPRR Manager, capturing review dates, audit outcomes, and exercising status. The BCP template was comprehensively reviewed since the last reporting period, with the majority of older plans now transitioned to the updated format. **BCP Template** **Audit Template.** **BCP Log.**	Fully compliant		
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	The EPRR team leads on delivering tabletop exercises using a range of scenarios to test the robustness of service-level Business Continuity Plans (BCPs). As of the reporting date, nine exercises have been completed since the last time of reporting, with further sessions scheduled. The exercise programme is now well-established, with regular business continuity exercises continuing across the Trust. Each session includes a tabletop discussion-based scenario followed by a structured debrief. Post-exercise reports are issued to services, outlining key actions and recommendations. These are monitored by the EPRR team and reviewed at the EPRR Committee to ensure accountability and continuous improvement. This programme not only validates the effectiveness of BCPs but also promotes awareness of business continuity across the organisation. Since the last reporting period, further work has been undertaken to fully embed the BCMS across the organisation. This has led to significant improvements in engagement with the process, which is reflected in improved compliance figures for BCP reviews, exercises and audits. **BCP Exercise Reports.** **Exercise Action Tracker.** **BC Incident Debrief Report.**	Fully compliant		
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The Information Technology department has submitted all evidence items for the Data Protection and Security Toolkit for the 2024-25 year. The toolkit was submitted at the end of June 2025, in line with the national deadline. This years submission is 'standards not met'. An improvement plan is in place and this will be reviewed by NHSE in July, at which point if the plan is agreed the status of the Trust's submission will change to 'approaching standards'. Confirmation was provided by L Magee (Head of Information Governance). **Data Protection and Security Toolkit.**	Partially compliant	This narrative may be updated prior to submission to the ICB following an update from the Head of IG. **If accepted by NHSE the compliance rating will change to Fully Compliant prior to our submission to the ICB.**	
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	The BCMS is monitored by the EPRR Manager and reviewed by the EPRR Committee. Key Performance Indicators (KPIs) used for monitoring are captured within the BCMS. Reports on these KPIs and the outcomes of exercises are included in the annual EPRR board report, ensuring that the board is kept informed of the BCMS status and any necessary corrective actions. **BC Policy (including BCMS).** **Board Report.** **Exercise Action Tracker.**	Fully compliant		
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The Trust has a process for internal audit as referenced in the BCMS within the BC Policy. An EPRR annual summary report, statement of compliance, and audit are provided to the Trust Board in the form of the NHSE EPRR Annual Self Assessment assurance documents and the EPRR annual board report. The Trust maintains a cycle of business for external audits, which EPRR aligns with, though EPRR has not had an external audit since the last core standards submission. This structured approach ensures that audits are conducted at planned intervals to confirm conformance with the business continuity programme, and outcomes are reported. **BC Policy (including BCMS).** **Board Report.** **Audit Template.**	Fully compliant		
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	The Trust has a process to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement, as referenced in the EPRR Policy and Business Continuity Management Plan. A record of BCP review dates, activation, and exercising is held by the EPRR Manager. Post-exercise reports are provided to services with actions and recommendations, which are captured and monitored by EPRR and reported into the EPRR Committee. Plan owners are required to review their plans annually, at a minimum, to ensure continuous improvement. This structured process ensures that improvements are documented, monitored, and integrated into the BCMS for ongoing enhancement. **BC Policy (including BCMS).** **Post Exercise Reports.** **Exercise Action Tracker.**	Fully compliant		
53	Business Continuity	Assurance of commissioned providers/ suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The BCMS outlines the process for assessing business continuity plans of commissioned providers or suppliers, ensuring alignment and interoperability with our own continuity arrangements. This process is detailed in our Business Continuity Management System. We encourage a Provider/Supplier Assurance Framework to verify that their business continuity arrangements meet our standards. A supplier audit template is included in the BC Policy for colleagues to use. The BCMS emphasises the importance of gaining assurance from providers or suppliers on whom we depend and requests visibility into their business continuity arrangements. Colleagues involved in contract management are reminded of this critical requirement. NHS Supply Chain has robust processes in place to assure continuity from their suppliers, ensuring that all dependencies are adequately safeguarded, as detailed at www.supplychain.nhs.uk/product-information/resilience/ **BC Policy (including BCMS).**	Partially compliant	N.B. Partially compliant: While the requirement for supplier Business Continuity Plans (BCPs) is referenced in the Trust's Business Continuity Policy as part of the BCMS, current evidence of supplier-level BCPs remains limited. Standard NHS Terms and Conditions of Supply require suppliers to maintain BCPs, including the following clause: "The supplier shall use reasonable endeavours to ensure its Business Continuity Plan operates effectively alongside the Authority's business continuity plan where relevant to the provision of the Services." However, as many contracts are established through national frameworks, it is challenging to obtain direct assurance at Trust level. **Both the ICB and NHS England have confirmed that it is the responsibility of individual Trusts to seek and hold this assurance.**	
Domain 10 - CBRN								
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Details of accountability for the Trusts HazMat and CBRN response, including emergency planning, are clearly outlined in the HazMat and CBRN Response Plan. Training and exercise requirements are also detailed within the HazMat and CBRN Response Plan to ensure readiness and proficiency in response protocols. Specific roles for hospital decontamination and their respective action cards are clearly defined within the HazMat and CBRN Response Plan, ensuring clarity and efficiency in emergency response efforts. The Decontamination Equipment Capabilities guideline specifies roles responsible for equipment checks and maintenance. **HazMat & CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.**	Fully compliant		
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	The Trust has implemented a HazMat & CBRN Response plan that comprehensively outlines response arrangements, operational protocols, required competencies, and procedures for managing hazardous waste. This plan includes a dynamic risk assessment process tailored to the presenting casualty, ensuring staff welfare is prioritised throughout and after the incident. The hazardous substance management pathway within the policy addresses the safe handling and disposal of hazardous waste, aligning with regulatory guidelines. The Clinical Business Manager/Specialty Business Manager for the Emergency Department assumes responsibility for conducting risk assessments (RAs) across Trust sites where decontamination may occur. These RAs evaluate potential impacts on staff, estates, and infrastructure, including considerations for access and egress. They also assess the impact of decontamination procedures on critical facilities and services, ensuring continuity of operations during emergencies. This structured approach ensures that Hazmat/CBRN risk assessments are robust, responsive to varying scenarios, and integral to maintaining the safety and functionality of Trust facilities. **HazMat & CBRN Response Plan.** **ED Risk Assessment.**	Fully compliant		
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Contact details for the 24-hour on-call consultant from the UK Health Security Agency are included in the HazMat and CBRN Response plan and displayed in the Emergency Department and ICC. This ensures accessibility for key clinical staff needing specialist advice during HazMat/CBRN incidents. Additionally, the plan outlines procedures for accessing other specialist clinical advice as needed, with relevant contact information provided. The plan also references NHS England guidance to further support clinicians in managing patient care effectively during such incidents. The plan also specifies the decision-making process that follows upon receipt of specialist advice. These arrangements ensure that staff are well-informed and prepared to access timely and appropriate specialist advice for ongoing patient treatment. **HazMat and CBRN Response Plan.**	Fully compliant		

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full	Action to be taken	Lead
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •Command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	The Trust has a robust HazMat and CBRN Response Plan, supported by the Decontamination Equipment Capabilities Guideline. Both documents are available on the intranet and in hard copy within the Emergency Department. Established procedures enable the activation and deployment of HazMat/CBRN-trained staff and Clinical Decontamination facilities. Predetermined decontamination locations are clearly defined, with separation of clean and dirty zones to ensure safe patient access and effective cordon control. The plans include protocols for both dry and wet decontamination, with clear decision-making criteria. Staff welfare and decontamination are prioritised, alongside business continuity measures to maintain patient flow via designated clean entry routes. The plans also cover hazardous waste management, the transition from response to recovery, and processes for replenishing PPE/PRPS. Staff training is delivered through the Northern Care Alliance, with in-house refresher sessions and local familiarisation provided by the EPRR Manager. This comprehensive approach ensures preparedness and supports swift recovery to normal operations following a HazMat/CBRN incident. **HazMat and CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.** **Training Records and TNA.**	Fully compliant		
59	Hazmat/CBRN	Decontamination capability availability 24-7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	The Trust maintains adequate and appropriate decontamination capability to handle self-presenting patients round the clock. Trained staff are readily available to operate these facilities, as outlined in the HazMat and CBRN Response plan, which specifies documented roles for the decontamination team, including the Entry Control/Safety Officer. CBRNe training and staff availability are overseen by the Clinical Educators for ED. All Band 7 ED staff have completed comprehensive CBRNe/HazMat and PRPS training, conducted over two days by the Northern Care Alliance, with plans for transition to NWAS training. A list of HazMat/CBRNe-trained personnel is displayed on the notice board in the ED Sister's office to ensure quick identification of trained staff. The Trust has assessed and identified suitable areas for mass decontamination at both hospital sites in collaboration with NHSE, NWAS, and LFRS colleagues. This collaborative effort ensures alignment of HazMat/CBRN plans and procedures with local area plans, enhancing readiness and response capabilities across the region. **HazMat and CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.** **Decontamination Equipment Audit.**	Fully compliant		
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/wpn-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20190110042314/https://www.england.nhs.uk/wp-content/uploads/2015/04/wpn-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	The Trust maintains appropriate decontamination equipment to ensure safe patient care and staff protection. An equipment inventory is overseen by the EPRR Manager, with regular checks to ensure functionality and readiness. Chorley & South Ribble Hospital has enhanced its facilities to increase capacity for self-presenting patients, while Royal Preston Hospital has a fixed decontamination unit capable of simultaneously treating up to six self-presenters. As a contingency, an articulated decontamination tent is retained on-site at Royal Preston for use during maintenance of the fixed unit. Both sites comply with NHS England guidance by maintaining the required number of PRPS suits, with servicing carried out in line with manufacturer protocols. The Trust is committed to the ongoing maintenance, servicing, and timely replacement of all decontamination equipment. Current PRPS stock will begin to expire in April 2027, and planning for replacement is already underway. **HazMat & CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.** **Decontamination Equipment Audit.**	Fully compliant		
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multiple organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Preventative maintenance is upheld to ensure continuous readiness for Hazmat/CBRN incidents within the Trust. The ED Team and EPRR Manager conduct annual PPM checks, most recently completed in July 2025 by the EPRR Manager and ED Unit Manager/Senior Sister. Ram-Gene monitors undergo monthly checks by the ED Team as per manufacturer instructions, with annual servicing facilitated by nuclear medicine colleagues and records maintained in ED. PRPS suits are monitored in accordance with Respirex guidelines under the oversight of the EPRR Manager. Decontamination facilities undergo annual testing to maintain operational integrity. Other essential equipment is routinely inspected by the ED team and/or EPRR Manager, with comprehensive records of all checks kept by the EPRR Team. Details of the PPM process are outlined in the Decontamination Equipment Capabilities guideline, ensuring adherence to industry standards and manufacturer recommendations. This structured approach, including oversight by the EPRR Committee, guarantees that equipment remains operational and ready to respond effectively to Hazmat/CBRN incidents while supporting ongoing business continuity arrangements. **Decontamination Equipment Capabilities Guideline.** **Decontamination Equipment Check List.** **Ram/Gene Monitoring Log.** **HazMat & CBRN Response Plan.**	Fully compliant		
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	The Trust maintains clearly defined waste management processes within its Hazmat/CBRN plans. For the safe disposal of PPE no longer required, staff render items unusable before collection and disposal by approved contractors, overseen by the Waste Minimisation Officer. Regarding waste water from decontamination, an established Memorandum of Understanding (MOU) with NWAS and Acute hospitals outlines procedures. The Trust contacts NWAS control to engage the on-call Tactical Advisor/NILO, who facilitates arrangements with Veolia for waste water disposal. This process is documented in the Hazmat and CBRN Response plan, ensuring clear and efficient coordination with emergency services. These arrangements align with regulatory requirements and support effective management of Hazmat/CBRN waste, reinforcing the Trust's commitment to environmental stewardship and operational readiness in response to incidents. **HazMat and CBRN Response Plan** **NWAS MOU for waste water disposal.** **Waste Management Policy.**	Fully compliant		
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Training for Hazmat/CBRN response at the Trust is comprehensive and aligned with our organisational Hazmat/CBRN plan and associated risk assessments. A Training Needs Analysis (TNA) ensures our training programme is tailored to the specific needs of our response staff, particularly focused on decontamination procedures. Currently, we have 73 staff trained in Hazmat/CBRN response, with ongoing efforts to expand this number through a rolling training programme. Training sessions cover essential areas such as PPE/PRPS use and decontamination practices, delivered both internally and through collaboration with Northern Care Alliance. To ensure continuity and high standards, we have 7 trained trainers within our Emergency Department who facilitate our internal Hazmat/CBRN training programme. These trainers have completed PRPS/CBRN Hazmat Train the Trainer Training through NWAS. With delivery of all HazMat and CBRN training moving across to NWAS, the first NWAS led train the trainer session took place in August 2024. All response staff are further supported by an internally developed e-Learning package and ongoing refresher training. Training records, including dates of attendance and certification, are held by the ED Clinical Educator, ensuring our staff remain proficient and up-to-date in Hazmat/CBRN response protocols; figures are also collated by the Trust training compliance team. This structured approach to training ensures our staff are well-prepared to manage Hazmat/CBRN incidents effectively, enhancing both operational readiness and patient safety. **EPRR TNA.** **HazMat & CBRN Response Plan.** **HazMat/CBRN Training Records.** **Blended Learning Figures.**	Fully compliant		
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	CBRN awareness training is mandatory for all Emergency Department staff, ensuring they understand the principles of Initial Operational Response (Remove Remove Remove) and the necessity for patient isolation when required. This training requirement is integral to our Emergency Department training programme, overseen by the Emergency Department Clinical Educator. Staff responsible for patient decontamination are specifically trained to implement a safe system of work, ensuring effective management in potential hazardous situations.At the previous reporting point, this standard was not fully compliant due to insufficient evidence of CBRN awareness among reception staff. This has now been addressed: reception colleagues have received specific training on identifying potentially contaminated patients and the appropriate escalation process. The Reception Supervisor has assumed responsibility for ensuring new staff are briefed on these procedures, and that any additional training needs are identified and acted upon. **EPRR TNA.** **HazMat/CBRN Training Records.** **Blended Learning Figures.** **CBRN eLearning.**	Fully compliant		
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	FFP3 masks and full PPE are readily accessible across the Emergency Department at Royal Preston Hospital (RPH) and Urgent Care/Emergency Department at Chorley District Hospital (CDH), supplemented by additional surge capacity throughout the trust. Fit mask testing is conducted routinely across all trust areas, accompanied by regular training sessions overseen by the Clinical Education Team. Both RPH and CDH hospitals maintain the minimum required number of operational PRPS, available around the clock. These suits undergo regular maintenance by Respirex, ensuring compliance with service and expiry dates, as well as necessary filter/battery changes. The EPRR Manager maintains detailed records related to PRPS maintenance. The HazMat and CBRN Response plan specifies the location of PPE and outlines appropriate usage based on risk assessments. Additionally, the Decontamination Equipment Capabilities guideline provides comprehensive instructions on PRPS use. **HazMat and CBRN Response Plan.** **Fit Mask Compliance Figures.** **Decontamination Equipment Capabilities Guideline.** **PRPS Maintenance Log.**	Fully compliant		
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	The Trust incorporates HazMat/CBRNe plans into its wider EPRR exercising and testing programme, with a structured schedule of exercises designed to test and enhance response capabilities. In April 2025, a live decontamination exercise was held at Royal Preston Hospital. Post-exercise reports identified key learning and recommendations, which have informed ongoing improvements to response plans. A follow-up training/exercise session took place in July 2025 to support local familiarisation and clarify role expectations based on lessons identified during the April exercise. Additional exercises are planned as part of the continuous improvement cycle to maintain preparedness for HazMat/CBRNe incidents. **Exercise Schedule.** **Post Exercise Reports.**	Fully compliant		

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence

Emergency Preparedness Resilience Response

Royal Preston Hospital,
Lancashire Teaching Hospitals NHS Foundation Trust

August 2025

Annual Report

Compliance |
Action plan for core standards 2024/25 |
Following last year's annual assurance submission of Substantial Compliance, the Trust had seven core standards that did not meet the Fully Compliant requirement. Over the past year, the EPRR team has worked to improve these standards, and five have now been upgraded to Fully Compliant. Two remain Partially Compliant, EPRR Resource and Assurance of Commissioned Providers'/Suppliers' Business Continuity Plans; with further details included in the 2025/26 compliance submission.

Core standards 2025/26 |
Following this year's review, the Trust will again submit an overall rating of Substantial Compliance, as defined in NHS Core Standards, with an overall score of 97%, an improvement from 89% the previous year. This reflects continued improvements in the Trust's EPRR arrangements and demonstrates steady progress towards full compliance in all areas.
As of this report, of the 62 core standards:

- 58 are assessed as Fully Compliant with supporting evidence
- 4 are assessed as Partially Compliant, with mitigating actions in place

Summary of Outstanding Standards and Associated Actions |

EPRR Resource: The Trust has approved the recruitment of an additional Band 6 EPRR Officer and is expected to be filled by October 2025. This will support improved compliance in this area.

Business Continuity: A supplier audit template has been developed to assess business continuity among commissioned providers. Although BCP requirements are referenced in the Trust's policy, assurance remains limited, especially for contracts managed through national frameworks. The ICB and NHSE have confirmed that Trusts are individually responsible for obtaining this assurance. EPRR will continue to prompt owners of BCPs for directly procured services and the Trust should also extend this process to Trustwide contracts.

Warning & Informing: The Trust has robust arrangements in place to support timely and structured communication via media and social media. However, two key policies required for ICB submission are overdue for review. At the time of reporting these have been reviewed by the Comms team and once uploaded to Heritage, this standard will be upgraded to fully compliant, prior to final submission to the ICB.

Data Protection & Security Toolkit: The IT department submitted all required evidence for the 2024–25 Data Protection and Security Toolkit by the national June 2025 deadline. The current status is 'standards not met' but an improvement plan has been submitted and will be reviewed by the NHSE towards the end of July/early August. If accepted, the status will move to 'approaching standards' and the core standard will be deemed fully compliant prior to final submission to the ICB.

Taking the above into account, the Trust's formal submission to the ICB will remain as Substantially Compliant, with 2 of the 62 core standards not yet fully met.

ICB Assurance Review
As part of the assurance process, the ICB will conduct an in-person review at RPH on 9 and 10 September, working closely with the EPRR Manager. All core standards will be examined with supporting evidence to validate the Trust's self-assessment. The goal is to ensure each rating is fully justified and provides assurance to both the ICB and NHSE.

In addition, the ICB may conduct a dip sample of 5–6 core standards to explore areas of concern or highlight good practice. We are currently awaiting confirmation on whether this will take place.

Information Cascade |
Martyn's Law - As of April 2025, Martyn's Law, formally known as the *Protect Duty*, has received Royal Assent. A preparation and consultation period is now underway to support organisations in meeting the new requirements, which must be fully implemented by April 2027.
Under the legislation, public venues with a capacity of over 800 people will be required to:

- Conduct annual terrorism risk assessments
- Develop and submit detailed security plans
- Designate a senior officer responsible for compliance and preparedness
- Ensure all staff have awareness of counter terrorism

The Trust has already taken steps to begin improving staff awareness and readiness:

- ACT (Action Counters Terrorism) Awareness eLearning is available to all colleagues. Work is ongoing to make this training mandatory.
- SCaN (See, Check and Notify) face-to-face sessions, delivered by Counter Terrorism Policing, have been held five times to date, with additional sessions planned.
- HIP (Hostile Information Plan): A site visit by Counter Terrorism Policing has been completed at Royal Preston Hospital (RPH) to assess vulnerabilities. We are currently awaiting the report, which will inform any necessary improvements to reduce the risk of being targeted.
- A HIP assessment will also be scheduled for Chorley District General Hospital.

Incidents |
IT/Bleep Disruption 28.09.24 – On Saturday, 28th September, a series of IT and communication system issues were reported across the Trust, affecting multiple departments and causing temporary disruption to several IT applications. The primary issues identified included:

- Difficulties with the internal bleep system
- Intermittent connectivity to IHDI

- Potential challenges with the fire alarm system at Chorley and South Ribble Hospital (CDH)

The emergency 2222 bleep system remained fully operational throughout the incident. However, the internal 66 bleep system was affected, resulting in temporary communication issues between staff. The IT team was promptly notified, and onsite engineers were quickly deployed to resolve the issues.

This incident presented several challenges, particularly regarding delayed communication and unclear escalation pathways. While the emergency bleep system remained functional and business continuity processes were implemented effectively in several areas, the event highlighted a need to strengthen escalation protocols and enhance real-time communication during similar disruptions.

Lessons identified during the debrief have been recorded and are being monitored by the EPRR Manager and EPRR Committee to ensure full implementation.

For further details, a copy of the debrief report is available upon request from the EPRR Manager.

NHS Blood & Transplant Amber Alert February 2025 – A notification was received from NHS Blood and Transplant indicating an amber alert due to a shortage of Group O cells. In response, the Emergency Blood Management Group was promptly convened in accordance with the Emergency Blood Management Arrangements Procedure. The group reviewed the relevant shortage plan and available guidance and developed strategies to manage the appropriate use of the affected blood and blood components. These strategies were then overseen and implemented by the Hospital Transfusion Team.

The frequency of meetings and the involvement of relevant colleagues were determined during the initial session and reviewed regularly as the situation evolved. The group met weekly at first, before transitioning to as-required meetings until the amber alert is lifted.

Loss of Hot Water Supply at RPH 29.06.25 - In the early hours of Sunday 29 June, Royal Preston Hospital experienced a loss of hot water. This was caused by a combination of infrastructure issues:

- A faulty pump in the condense receiver
- Underperforming solenoid valves in the hot well makeup tank
- Contractor-related diversion of condense away from the hot well due top faulty boiler economiser

These issues combined led to the hot wells running dry, meaning no water supply to the boilers which need to be supplied with hot water to function. The engineering team carried out a controlled and phased recovery, using manual overrides and a slow reactivation process to safely bring the system back online. Full service was restored by 17:21 the same day.

The hot water incident was managed safely and efficiently, thanks to excellent cross-team working, technical expertise, and robust continuity planning. The response minimised service disruption and maintained safe patient care. Learning from this

event will help the Trust further strengthen its resilience, decision-making processes, and response capabilities for future infrastructure-related challenges.

Lessons identified during the debrief have been captured and are being monitored by the EPRR Manager and EPRR Committee to ensure their full implementation. For further details, a copy of the debrief report is available upon request from the EPRR Manager.

Industrial Action Resident Doctors: 25-30/07/25 - Ahead of the industrial action, the Emergency Planning Group met on two occasions to review potential impacts and develop mitigation plans. An oversight briefing was also provided to the Senior Leadership Team (SLT) on a Friday morning to ensure awareness and preparedness.

An Incident Management Team (IMT) was established for the duration of the industrial action, operating a 24/7 Command-and-Control structure in line with EPRR standards. This ensured a coordinated and robust response throughout the period. Nationally, the incident was not led through EPRR channels and was instead classified as business as usual by NHSE, with reduced reporting requirements to the ICB.

No significant issues were identified during or following the industrial action.

EPRR Training & Exercising Programme |
Training |
EPRR Awareness - EPRR awareness is embedded within the Trust's Fire Safety eLearning package, making it part of the mandatory training for all staff. Currently, just under 8,000 employees have completed this training within the last two years. This broad level of awareness is crucial to building a resilient workforce capable of responding effectively to emergencies. It is essential that as many colleagues as possible are familiar with EPRR protocols to ensure a coordinated and effective response during incidents, safeguarding both staff and patient safety.

Principles of Health Command (NHSE) Training – This is a four-hour online training session delivered by NHSE North West, designed to equip Tactical and Strategic Commanders with the knowledge and skills needed to lead or support emergency responses. The Trust is currently 72% compliant for Strategic Commanders and 90% compliant for Tactical Commanders.

Legal Awareness – No additional legal awareness sessions have taken place this year. The Trust is currently 61% compliant for Strategic Commanders. This figure has slightly decreased since last year due to the addition of several new colleagues to the Executive on Call rota (Strategic).

SCaN (See Check and Notify) - See, Check, and Notify (SCaN) training is an innovative training programme borne out of years of research and delivered by qualified Counter Terrorism personnel, SCaN aims to teach delegates how to: **See**: Recognise what's suspicious, and what isn't, **Check**: Understand the impact of

friendly engagement to confirm or refute your suspicions and **Notify**: Know where and how to report if your suspicions are confirmed. SCaN aims to help organisations maximise safety and security using our existing resources. Our people are our biggest advantage in preventing and tackling a range of threats, including criminal activity and terrorism.

SCaN training empowers staff to correctly identify suspicious activity and know what to do when they encounter it. It helps ensure that individuals or groups seeking to cause our organisation harm are unable to get the information they need to plan their actions. In addition to this, the skills staff have learnt help to provide an enhanced visitor/patient experience.

We have delivered 6 courses in the Trust to date with two further dates scheduled, attendance is extended to all Trust colleagues. The most recent course was also attended by colleagues from LSCFT and ELHT.

ACT Awareness (Action Counters Terrorism) – In addition to the SCaN training an eLearning package has been developed to help all colleagues enhance their awareness. To date, 41 colleagues have completed this. Work is ongoing to make this training mandatory.

CBRNe/HazMat – The training programme for Emergency Department (ED) staff is now fully established, with colleagues attending a comprehensive two-day course delivered by the Northern Care Alliance. This course covers all aspects of CBRNe/HazMat response, ensuring our teams are well-prepared for these critical situations.

Currently, 73 ED staff members are fully compliant with their CBRNe/HazMat training, which includes RamGene radiation monitoring and the safe use of Personal Respiratory Protection Suits (PRPS). This represents a slight reduction from last year, primarily due to staff turnover.

Due to increased operational pressures, our RPH ED educators have been unable to deliver in-house training and annual refresher courses, which are vital to maintaining staff confidence and competence. However, 182 ED colleagues have completed the CBRNe/HazMat eLearning package, developed in-house last year and now available via Blended Learning for ongoing reinforcement.

To further support the clinical educators, local decontamination awareness training has been developed by the EPRR team. This training equips ED staff with the specific knowledge required to:

- Recognise and respond to CBRNe/HazMat incidents
- Operate relevant decontamination equipment
- Safely manage self-presenters requiring hospital decontamination

This local training builds upon the foundational knowledge provided by the Northern Care Alliance and supports staff in delivering a safe and effective decontamination response.

Business Continuity Awareness Workshop – Two business continuity workshops have taken place, with approximately 50 colleagues attending across both sessions. These workshops provided attendees with a clearer understanding of the full business continuity planning cycle and supported the review and enhancement of existing business continuity plans. Feedback following the sessions was extremely positive.

Exercising |
6 Monthly Communications Exercise – Since the last report, four communications exercises have been conducted:

- Exercise Reindeer – 07/11/24
- Exercise Red One – 18/11/24
- Exercise Toucan – 12/05/25
- Exercise Phoenix – 21/05/25

In line with EPRR requirements, the Trust is required to conduct at least one communications exercise every six months.

- Exercises Reindeer and Red One involved unannounced calls to Switchboard, with a M/ETHANE report used to test the major incident alerting cascade from Switchboard to incident commanders.
- Exercise Toucan was the annual NHSE led communications exercise, designed to test alert mechanisms into trusts.
- Exercise Phoenix was the Trust's routine internal exercise, testing the call-out process for all colleagues on the major incident call out list.

The next communications exercise is scheduled for November 2025.

Command Post Exercise – Exercise Arkwright, a mass casualty scenario, took place at Royal Preston Hospital (RPH) on 02/06/25. The Trust is required to conduct a Command Post Exercise at least once every three years, providing colleagues with the opportunity to perform their incident response roles in a controlled environment.

The exercise was well attended by internal operational colleagues from ED, Critical Care, Major Trauma, Theatres, Estates, Security, Porters, Catering, IT, Comms, Diagnostics, Switchboard, and Mortuary, with external support from colleagues at LSCFT, ELHT, the Critical Care Network, and NWAS.; however, limited participation from Tactical and Strategic Commanders reduced the overall effectiveness of the exercise, particularly in testing the full command, control, and communication processes outlined in Trust response plans.

Live Exercises
In addition to the Command Post Exercise, three live exercises have taken place:

- Exercise Hose Down – conducted on 24/09/24 and 02/04/25 at RPH. These decontamination exercises, supported by surrounding Acute Trusts and NWAS, involved volunteers acting as live casualties. The sessions allowed

trained staff to apply their practical skills and familiarise themselves with the new Decontamination Unit at RPH.

A further decontamination exercise is scheduled for RPH, and one is planned for Chorley District Hospital (CDH) to ensure staff there are also confident and competent in delivering a decontamination response. While RPH is the main receiving site, CDH may still receive self-presenters, and staff need to be prepared accordingly.

Baby Abduction Exercise 19.11.24 - This exercise was designed to test and refine ward-level response protocols in a high-risk, emotionally charged scenario.

In preparation, a simulation doll (hereafter referred to as the "doll") was placed in a cubicle on Ward 8 several days in advance. This allowed staff to treat the doll as they would a real patient, forming an attachment and following standard care protocols. On the day of the exercise, the simulated ‘abductor’ gained access to the ward by tailgating a staff member through the main entrance. The doll was then removed from the ward and taken off-site after being swiped out by another staff member.

This scenario tested the ward’s ability to identify, escalate, and respond to an abduction in real time, while maintaining patient safety. The exercise provided a safe, realistic environment for staff to practise their response to such a critical incident.

Business Continuity - Since the last report, ten business continuity exercises have been conducted, with additional sessions scheduled. While the programme is progressing well, a number of last-minute cancellations have occurred due to operational pressures.

Lessons identified during these exercises are being recorded by the EPRR Manager and are monitored through the EPRR Committee to ensure continuous improvement and oversight.

Tabletop Exercises – Four tabletop exercises have taken place during the reporting period:

Mortuary Surge Management – 21/10/24
This exercise assessed the Trust’s Mortuary Surge Arrangements in managing increased mortality pressures caused by winter demand or a mass fatality incident. It evaluated LTHTr’s capacity management, business continuity, communication with external partners, and compliance with Human Tissue Authority (HTA) standards.

Primary Care GP Collective Action – 03/12/24
The aim of this exercise was to assess the Trust’s ability to respond to increased patient flow and capacity challenges following a reduction in primary care services. It focused on maintaining patient safety, service continuity, and optimising resource

allocation during heightened demand. The session was well attended by both internal and external colleagues, with strong engagement from all participants.

Exercise Creta – 07/01/25
Requested by NHSE for all acute providers in the North, this exercise tested the Trust's internal capacity and capability modelling in the event of a mass casualty incident. It focused on:

- Creating surge capacity
- Cohorting patients to enable ambulance turnaround
- Assessing operational impacts
  Participants included staff from ED, Critical Care, Capacity Management, Integrated Discharge Services, and partners from LSCFT.

Exercise Formo – 10/06/25
A follow-up to Exercise Creta, this ICB led session sought assurance that the Trust could respond effectively to a mass casualty incident. It also aimed to inform potential updates to the North West casualty distribution plan, though no changes have been communicated as yet. Attendees included LTHTr colleagues from ED, Critical Care, and Capacity Management, alongside representatives from surrounding acute trusts. A full report from the ICB is awaited.

Exercise Kaus Australis – 08/07/25
Delivered by the North West region as part of NHS England's 7-Year EPRR Exercise Programme, this regional exercise tested the NHS's response to a national power outage (NPO) resulting in loss of electrical power and fuel access.
The exercise was attended by:

- Craig Carter, Director of Finance
- Lee Taylor, Head of Estates Engineering
- Sam Hughes, EPRR Manager

A full report from the ICB is awaited.

Union representatives are invited to EPRR training and exercising sessions, with attendance noted at both Exercise Arkwright and the recent Business Continuity Awareness Workshop.

Plans Policies & Procedures |
All EPRR owned plans have undergone their annual review, with any updates documented in the amendment history of each respective plan.

Business Continuity Plans – At the time of reporting, only two BCPs within the Trust are currently overdue for review. This has been escalated via the EPRR Committee and to divisional managers for oversight, with completion expected in the coming weeks.

Since the last report, colleagues have actively addressed historical gaps in BCP reviews. Internal audits of BCPs are now underway, and the BCP exercising schedule has been fully embedded into business-as-usual practice.

All BCPs are accessible via the EPRR Intranet pages, and hard copies are stored in the Major Incident cupboard at Royal Preston Hospital.

Current/Potential Risks |
Trustwide Alerting System – During recent incidents and exercises, a gap has been identified in the Trust's ability to communicate quickly and efficiently with a large number of colleagues. The Telecoms team is currently exploring options that align with systems used by other Trusts in the OneLSC group, to ensure consistency in tools and approaches. Available options will be presented at the next EPRR Committee meeting for discussion.

Powered Respirator Protective Suits - PRPS play a critical role in protecting staff during Chemical, Biological, Radiological, and Nuclear (CBRN) incidents. The Trust is legally required to maintain a specified number of operational PRPS at each site with an Emergency Department (ED).

The current stock of PRPS is due to expire between April and October 2027. To remain legally compliant and maintain operational readiness, timely replacement is essential. A replacement plan has been developed, with an estimated cost of £153,250, and a paper has been submitted to the EPRR Committee. Finance colleagues have been informed to ensure this is factored into future budget planning.

Aligning the replacement plan with NHS requirements and the NHS Core Standards for EPRR will safeguard the Trust's ability to respond to CBRN incidents and ensure the health and safety of staff.

Resource & Funding |
EPRR Mandatory Training Costs – While EPRR training has been ongoing within the Trust, it has been funded through a successful £15,000 funding bid. Moving forward, future budgeting for EPRR training will need to be addressed to ensure ongoing competency and compliance of command staff with their EPRR training portfolios.

Strategic and Tactical Incident Coordination Centres (SICC/TICC) – The Gordon Hesling Conference Room serves as the Trust's dual-purpose space for major incidents, functioning as the Strategic Incident Coordination Centre (SICC). Following its extensive refurbishment, it has proven effective.
The bed hub at RPH, intended to serve as the Tactical Incident Coordination Centre (TICC), was identified as inadequate for dual-purpose use following its activation in late 2022. Approval was granted to explore minor refurbishment of this space, but as of the time of reporting, no progress has been made.

EPRR Function – Since mid-September 2024, the governance structure for EPRR has included:

- Katie Foster-Greenwood (COO) – Accountable Emergency Officer
- Sam Hughes – EPRR Manager, responsible for day-to-day implementation

The Trust’s current reliance on a single EPRR individual continues to pose a risk to both operational continuity and statutory compliance. However, funding has been approved for a Band 6 EPRR Officer, with recruitment expected to begin in the coming months.

While this addition will help strengthen the EPRR function, a team-based approach is recommended to further mitigate risk, improve preparedness, and ensure the safety of patients, staff, and services during emergencies.

Report End
Sam Hughes | EPRR Manager

13. ITEMS FOR INFORMATION

13.1 AHP SAFE STAFFING REPORT

Information Item

*Full report in ancillary pack

13.2 DATE, TIME AND VENUE OF NEXT MEETING:

Information Item | M Thomas | 12.25pm

2 October 2025 at 9:15 am at Lecture Room 1, EC1 Royal Preston Hospital