NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING

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30 October 2025

13:00 GMT Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

0.0 - Agenda (PI) - Council of Governors - 30 October 25.pdf

Council of Governors

30 October 2025 | 1.00pm
Lecture Room 1, Education Centre 1, Royal Preston Hospital

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	M Thomas
2.	Apologies for absence	1.01pm	Verbal	Information	M Thomas
3.	Declaration of interests	1.02pm	Verbal	Information	M Thomas
4.	Minutes of the previous meetings held on 24 July 2025	1.03pm	✓	Decision	M Thomas
5.	Matters arising and action log	1.04pm	✓	Information	M Thomas
6.	Chairman and Chief Executive's opening remarks	1.05pm	Verbal	Information	M Thomas/ S Nicholls
7.	Nomination of Lancashire County Council Appointed Governor	1.15pm	✓	Decision	J Foote
8.	Board Committee Chairs' Reports	1.20pm	✓	Assurance	Non-Executive Directors
9.	Update from Care and Safety Subgroup	1.40pm	Verbal	Information	J Miller
10.	Update from Membership Subgroup	1.50pm	Verbal	Information	S Brennan
11.	SAFETY, QUALITY, WORKFORCE AND PERFORMANCE				
11.1	Infection Prevention and Control Annual Report	2.00pm	✓	Assurance	S Morrison
11.2	Winter Planning	2.15pm	✓	Assurance	K Foster-Greenwood
12.	STRATEGY AND PLANNING				
12.1	Single Improvement Plan	2.25pm	✓	Information	A Brotherton
13.	GOVERNANCE AND COMPLIANCE				
13.1	Annual Members Meeting Analysis Report	2.35pm	✓	Information	J Foote
13.2	Council of Governors KPIs	2.45pm	✓	Decision	J Foote

№	Item	Time	Encl.	Purpose	Presenter
13.3	Appointment of External Auditors	2:55pm	✓	Decision	Audit Chair
14.	ITEMS FOR INFORMATION (taken as read)				
14.1	Governor opportunities summary		✓		
14.2	Governor issues report		✓		
14.3	Corporate and Governor Calendar		✓		
14.4	**Minutes of Governor Subgroups**: (a) Care and Safety Subgroup – 10 July 2025 (b) Membership Subgroup – 5 August 2025 (c) Chairs, Deputy Chairs and Lead Governor – 15 October 2025		✓ ✓ ✓		
14.5	Date, time and venue of next meeting: *20 January 2026, 1.00pm, Lecture Room 1, Education Centre 1 - Royal Preston Hospital*	2.59pm	Verbal	Information	M Thomas
15.	REVIEW OF MEETING PERFORMANCE				
15.1	Discussion on how the meeting in public has been conducted	3.00pm	Verbal	Information	All
16.	RESOLUTION TO REMOVE PRESS AND PUBLIC				
16.1	Resolution to exclude members of the press and public	3.00pm	Verbal	Information	M Thomas

1. CHAIR AND QUORUM

Information Item | M Thomas | 1.00pm

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 1.01pm

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 1.02pm

4. MINUTES OF THE PREVIOUS MEETING HELD ON 24 JULY 2025

Decision Item | M Thomas | 1.03pm

REFERENCES

Only PDFs are attached

4.0 - Minutes - 24 July 2025 Council of Governors (part I) approved.pdf

Council of Governors Public Meeting

24 July 2025 | 10.00am

Lecture Hall, Education Centre 3, Chorley & South Ribble Hospital

Present:

Mike Thomas	Chair
Pav Akhtar	Public Governor (via MS Teams)
Takhsin Akhtar	Public Governor (via MS Teams)
George Bailey	Public Governor
Sheila Brennan	Public Governor
Darrell Brooks	Public Governor
Michelle Brown	Appointed Governor *(joined the meeting following item 54/25)*
Sonia Connell	Staff Governor
Philip Curwen	Public Governor
Lou Jackson	Appointed Governor
Angela Kos	Public Governor
Janet Miller	Public Governor
Carole Oldcorn	Public Governor
Enid Povey	Public Governor
Christine Pownall	Public Governor
Frank Robinson	Public Governor
Graham Robinson	Public Governor
Suleman Sarwar	Appointed Governor (via MS Teams)

Apologies:

Paul Brooks	Public Governor
Margaret France	Public Governor
Tom Ramsay	Staff Governor
Graham Fullarton	Public Governor

In attendance:

Tim Ballard	Non-Executive Director (via MS Teams)
Karen Lawrenson	Corporate Affairs Officer *(minutes)*
StJohn Crean	Non-Executive Director (via MS Teams)
Karen Deeny	Non-Executive Director (via MS Teams)
Jennifer Foote MBE	Director of Corporate Affairs
Adrian Leather	Non-Executive Director
Silas Nicholls	Chief Executive
John Schorah	Non-Executive Director
Tim Wheeler	Non-Executive Director (via MS Teams)
Jo Wiseman	Interim Business Manager, Corporate Affairs

Report Presenters:

Ailsa Brotherton	Chief Strategy and Improvement Officer *(item 60/25 via MS Teams)*
Katie Foster-Greenwood	Chief Operating Officer *(item 56/25 via MS Teams)*

Sarah Morrison Chief Nursing Officer/Deputy Chief Executive *(item 58/25 via MS Teams)*

50/25 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.

51/25 Declaration of interests

There were no conflicts of interest declared by Governors in respect of the business to be transacted during the meeting.

52/25 Minutes of the previous meeting

It was agreed that the minutes of the meeting held on 24 April 2025 were approved as a true and accurate record.

53/25 Matters arising and action log

A copy of the action log had been circulated, and it was noted that there were no outstanding actions.

54/25 Update on Council Membership, Including Appointment of Local Authority Members

Council was notified of changes in membership since the last meeting: Nigel Garrett, University (Partnership) Governor (resigned) Lesley Purcell, Staff Governor (ineligible following resignation from staff position); Eddie Pope, (ineligible following local elections); and Feixia Yu's (term ended due to non-attendance at required meetings).

Chorley Council had formally nominated Councillor Michelle Brown to replace Councillor Alistair Bradley, whose term had concluded. No nomination had yet been received from Lancashire County Council to replace Eddie Pope.

The Council RESOLVED that the appointment of Councillor Michelle Brown as Appointed Governor for Chorley Council be endorsed for a term of office of one year.

55/25 Chairman and Chief Executive's opening remarks

The Chair reflected on the NHS Ten Year Plan and the potential dis-establishment of Councils of Governors from Foundation Trusts, as mentioned therein. No formal guidance or policy had been issued, and the matter remained unassigned within government departments. Trusts had been advised to proceed with scheduled elections. The Council discussed future recruitment challenges and the potential shift to a patient representative model. Concerns were expressed about the lack of consultation and its impact on Governor engagement. Digital patient feedback developments were anticipated post-Parliament recess, and it was agreed to monitor national guidance and local practices.

The Chief Executive provided an update on the upcoming five-day resident doctors' strike, with preparations underway to ensure coverage across specialties and prioritisation of

life-threatening procedures. NHS England had issued stricter guidance, and while cancellations had been minimised, some had been necessary to maintain patient safety. The strike had seen lower turnout and mixed reactions among medical staff, with diminishing public support. Financial scrutiny of strike-related costs was expected, and further industrial action may occur every four to five weeks. Emphasis was made on the importance of maintaining safe conditions and preserving relationships with medical colleagues.

Positive feedback had been received from recent CQC visits to the surgical division and radiology, with high staff engagement and service improvements noted. The radiology inspection returned zero recommendations, marking a significant achievement. National performance tables had been delayed due to data issues, but revised figures were expected to be more favourable.

Financially, the organisation had identified £60 million in savings for the year, with a full-year effect of £80 million. Efforts were focused on achieving those savings to reduce future targets and reach a break-even position by April 2027. Staff redundancies had been minimal due to effective vacancy management and redeployment strategies. Acknowledgement was given to the impact of savings measures on patient services and staff, reaffirming the commitment to managing changes responsibly and transparently.

Sickness rates had declined over three consecutive months, particularly in long-term cases, with current levels at 5.8%. Measures were in place to address short-term sickness, aiming to reduce rates below the national average.

Strategic developments included progress on pathology service consolidation and vascular transfer, with potential delays depending on public consultation requirements. A recent meeting with senior government officials focused on securing investment for a pathology hub on the new hospital site, and reviewing A&E opening hours at Chorley, with discussions around funding and operational feasibility.

56/25 Approach to Surge Planning

The Chief Operating Officer attended to present this item.

The Council received an update on winter planning for 2025/26, reflecting on lessons learned from the previous year. The plan prioritised admission avoidance, reduced emergency department pressure, improved ambulance handovers, and faster discharges. Without intervention, modelling had projected a bed gap of 40–114 beds and worsening four-hour ED performance. Initiatives trialled in 2024/25 included extended same-day emergency care, weekend acute medical cover, a senior decision-maker pilot at ED, increased paediatric capacity, and expanded discharge lounge use. While performance improved by 1.7% and patient boarding reduced, ambulance handovers worsened, and winter beds couldn't be mobilised due to staffing shortages. The senior decision-maker pilot was discontinued due to limited impact as a consequence of pressures within community pathways. Planning for 2025/26 began earlier, with all schemes to be approved by July and supported by tighter controls and revised escalation policies.

The Trust was developing robust discharge lounge services at both Preston and Chorley sites under centralised management. Concerns about patient boarding and delayed discharges was acknowledged, with a focus on reducing length of stay, especially for those classified as 'days kept away from home'. A programme had been implemented to

improve discharge processes, reduce deconditioning, and apply a strengths-based approach. Two cohort wards had shown early success in improving discharge outcomes and reducing ward moves.

Clarity was provided that the previously cited bed gap referred to last year's modelling and that while no new beds were added, contingency plans remained in place. The preferred strategy remained community-based care and admission avoidance, with additional beds as a last resort. Concerns about community capacity and re-admissions were to be addressed through strengthened collaboration with local authorities, primary care, and community services. Patients requiring care packages were not discharged until arrangements were in place, and a responsive reassessment process was being developed to adapt to evolving needs and reduce re-admissions.

57/25 Update from Chairs of Subgroups

The Chairs of the Care and Safety and Membership Subgroups summarised the topics discussed at recent meetings and the following points were noted:

a) Care and Safety Subgroup (CaSS)

At the 10 July meeting, attention was drawn to the Blue Badge scheme and the upgraded parking software, with concerns raised about the accessibility of visitor information on the Trust website, which was subsequently being updated. The patient experience update confirmed that 8 beds on Ward 12 had been closed to facilitate the expansion of the surgical assessment unit on Ward 3, with no loss of bed capacity. Boarding across wards remained an ongoing issue. Patient involvement update included the review of patient leaflets, with future leaflets to include links to the research department. The Carers Forum continued to meet, and Age-UK Lancashire now had office space at Chorley Hospital, though it was not accessible to patients. Concerns were raised regarding the future of Healthwatch and the impact of digital exclusion, particularly on older patients. Reflections were shared on recent visits to the DOSA unit and pharmacy at RPH, noting a lack of continuity in dementia-friendly practices and the decline of previously successful initiatives. The importance of maintaining up-to-date patient and visitor information on the Trust homepage was emphasised. Concerns were raised about the staffing of PALS offices, with reports of unanswered calls and delayed responses.

b) Membership Subgroup

A meeting was held on 5 June during which the appointment of a new Deputy Chair was confirmed. Two primary issues were discussed. Firstly, the accuracy of the membership records was reviewed. While a process exists to maintain records based on information provided to the Civica system, there was uncertainty over retrospective validation, raising concerns about the reliability and representativeness of the data. Secondly, the meeting addressed membership engagement. Financial constraints were acknowledged, and the group discussed the potential for low-cost community events to enhance public engagement.

An update was provided confirming that the membership register was reconciled monthly against notifications, such as deaths, and was maintained as a live document. However, it was noted that the system relied on external notifications.

58/25 Patient Experience and Involvement Annual Report

The Chief Nursing Officer and Deputy Chief Executive attended for this item.

The report summarised the final year of the Trust's 2022–2025 strategy. It confirmed that the strategy, co-produced with patients, carers, staff, and Governors, had driven improvements in patient experience through three core themes: insight, involvement, and improvement. Key achievements included a 76% rise in compliments, an 8% drop in complaints, and a 4.7% increase in Friends and Family Test response rates. While Day Case and Outpatient services consistently exceeded national satisfaction targets, Maternity, Inpatient, and Emergency Departments fell short in some quarters. The Trust introduced new services such as youth workers, stoma-friendly bathrooms, and enhanced interpretation support, and launched a Patient Experience Portal. National survey results were mixed, with strong performance in cancer care but areas for improvement in urgent and emergency services. As the Trust transitions to a new Single Improvement Plan, focus would continue on inclusion, feedback from underrepresented groups, and embedding patient experience across all services.

The Council commended the reduction in complaints despite operational pressures, crediting early engagement and ward-level resolution. Suggestions to improve the tone and clarity of complaint responses were acknowledged for future review. An update on the Hospice at Home service confirmed it currently operated during daytime hours only, with efforts ongoing to secure funding for 24/7 provision. Concerns about wait times and capacity were noted, with the Trust monitoring those through constitutional returns and working with community partners to address pressures and reduce corridor care.

High emergency department attendance, particularly among patients with mental health needs, was highlighted. The Trust was collaborating with mental health services and had a high-intensity user service in place, with plans to expand support. A multi-agency approach was being pursued to address complex social needs, aligned with the NHS 10-year plan. The Trust's social value strategy also aimed to leverage its role as a major employer to support community-based prevention and rehabilitation.

A query on our health days for patients with learning disabilities confirmed that while there was no fixed schedule, events were shaped by feedback from those with lived experience. The Council was also informed of national research funding bids involving the Trust aimed at improving community-based mental health care and reducing pressure on acute services.

59/25 Board Committee Chairs' Reports

The Non-Executive Directors provided an overview of the areas of focus for their respective assurance committee.

a) Safety and Quality Committee:

The Safety and Quality Committee reviewed key risks including urgent and emergency care experience, Clostridium difficile infection rates, and health inequalities. Emergency Department pressures remained high, with a national survey action plan and monthly updates from the Patient Care Experience and Involvement Group in place. Infection control improvements reduced C. difficile cases, lowering the risk score from 20 to 16. Health inequalities were being addressed through the population health improvement plan. Assurance was provided on maternity safety, including CNST standards and a

sensitive response to a rare maternal death. Progress was noted, although Maternity and Neonatal Voices Partnership attendance lagged due to ICB funding constraints. A fourth Ophthalmology Never Event triggered internal and external reviews, including a 48-hour service pause and Royal College of Ophthalmology involvement. Medical safe staffing was reviewed, with recognition of the lack of national benchmarks and the need for improved reporting. The Committee recommended Board approval of the Annual Patient Experience Report, Infection Prevention and Control Annual Plan, and the Patient Safety Incident Report Framework. It also endorsed a new Health and Safety Workstream within the Single Improvement Plan.

Concerns about continuity of issues raised in meetings was addressed, with confirmation that all actions were tracked via Committee action logs and escalated as needed. While not all items appeared in every report, governance processes ensured compliance with Care Quality Commission standards. Outstanding CQC “must do” actions were scheduled for discussion at the next Committee meeting, with a closure report to follow. The Ophthalmology Never Event prompted significant concern, with immediate actions taken and ongoing monitoring through the safety dashboard. High activity levels were identified as a contributing factor, and efforts were underway to prevent recurrence.

b) Finance and Performance Committee (FPC):

At its meetings on 22 April, 27 May, and 24 June 2025, the Finance and Performance Committee reviewed strategic and operational risks. While principal risk scores remained unchanged, a new risk was identified around diagnostic access, and a shift in productivity risk appetite from ‘open’ to ‘cautious’ was proposed due to financial pressures. Urgent and emergency care performance showed slight improvement, though discharge delays and elective backlogs persisted. Cancer and diagnostics performance improved but remained reliant on temporary capacity, raising sustainability concerns. The Trust ended 2024/25 on forecast but began 2025/26 with a £5 million deficit, largely due to unidentified savings in the Waste Reduction Programme (WRP). Although the WRP delivery gap narrowed, it remained a key risk, with significant cash flow pressures expected in Q2. In June, the risk score for Principal Risk 13 was increased due to concerns over cash availability beyond August. Procurement governance improved with new KPIs and oversight, though some accountability gaps persisted. The Committee noted progress in the Single Improvement Plan, which had delivered 14 of 25 exit criteria, and endorsed the refreshed Green Plan for Board submission.

£60 million in savings had been identified, with the focus now shifting from planning to delivery. Operational risks remained largely unchanged, with incremental improvements observed across most areas, although continued to lag behind targets. Some Q1 milestones in the Single Improvement Plan were missed but were under close monitoring. The Committee assured the Board of progress in performance and governance, while highlighting fragilities in WRP delivery, diagnostic sustainability, and unfunded planning expectations.

A query on the Trust’s cash position and its impact on local suppliers confirmed that while national guidance required adherence to contractual terms, the Trust applied a flexible approach for small local businesses to support the local economy. Procurement governance continued to improve, with a reduction in single tender waivers and the introduction of KPIs in June to strengthen oversight.

c) Workforce Committee:

At its 13 May meeting, the Workforce Committee reviewed key risks and performance indicators, highlighting ongoing challenges in workforce planning due to long-term sickness and fragile services, particularly in radiotherapy and clinical support. While collaboration with One LSC and automation offered long-term solutions, short-term risks remained. Medical job planning was prioritised for oversight. The sickness absence rate averaged 6.47%, with mental health accounting for nearly 30% of absences. Psychological wellbeing services were under pressure due to long waits for intensive therapy. Appraisal compliance reached 90.8%, though disparities persisted, especially in Hosted Services. Actions were taken to improve appraisal quality and alignment with corporate goals. The Committee reviewed the Freedom to Speak Up report, noting a rise in concerns attributed to improved reporting mechanisms. Estates and Facilities remained a concern due to low engagement. The National Staff Survey showed declining satisfaction, prompting a corporate action plan focused on wellbeing, flexible working, and inclusion. The Committee recommended the WRES and WDES reports for Board approval, noting progress in representation and perceptions of equality, but ongoing issues with bullying, discrimination, and under-representation in senior roles. Alerts to the Board included short-term workforce planning risks, pressures on psychological wellbeing services, and recruitment challenges in specialist areas.

At the 8 July meeting, the Committee focused on delivering key actions swiftly. Oversight was strengthened through tighter vacancy panel controls and executive scrutiny, particularly to protect critical administrative roles. A deep dive into staff sickness had been undertaken, with mental health cited as the leading cause. Initiatives in occupational health and psychological safety were supported, targeting specific teams and encouraging proactive management.

The Committee received updates on the social value report and health and wellbeing strategy, both showing progress. The annual culture report identified areas for improvement in race and disability support. Mental health-related absences were slightly below regional comparators. It was acknowledged that not all mental health issues stemmed from work, and a broader provision was needed across Central Lancashire. A detailed review of sickness support mechanisms revealed inconsistencies in managerial responses. A business case for additional psychological support was approved, with a specialist officer joining the occupational health team soon. Emphasis was placed on supporting staff transitioning from short- to long-term absence, improving the working environment, and addressing stress, anxiety, and depression. Managerial flexibility and early intervention were highlighted as key to preventing escalation.

d) Audit Committee:

The Audit Committee reviewed assurance, governance, and risk matters, noting that internal audit progress was on track with reviews underway in mandatory training, PSIRF, and health and safety. The draft Head of Internal Audit Opinion for 2024/25 offered moderate assurance, a downgrade from the previous year, reflecting financial and operational pressures and the Trust's placement in NHS Oversight Framework Segment 4. Forty-nine audit recommendations remained open. The Committee approved the 2025/26 internal audit, counter-fraud, and external audit plans. The external audit flagged risks in financial sustainability, procurement, and asset valuation. Concerns were raised about procurement practices, particularly the high number of single tender waivers, prompting calls for cultural and procedural improvements. Data quality assurance showed progress in admissions coding, although outpatient and ED data required further attention.

The updated Risk Management Policy was endorsed for Board approval, aligning with the revised Board Assurance Framework. Alerts to the Board included procurement concerns, unresolved audit arrangements with One LSC, and overdue clinical audit actions in maternity, obstetrics, and urology. The Committee also advised monitoring staff expenditure and evaluating new risk identification methods, including cybersecurity. Assurance was provided on data quality improvements and the robustness of audit and governance processes.

Positive developments were noted in managing staff sickness, attributed to effective control measures and supportive interventions. Financial concerns included a failure to collect outstanding prescription charges, identified as an area for immediate corrective action to support savings targets. The Committee emphasised learning from best practice regionally and nationally and acknowledged the persistent risk of fraud, underscoring the need for continued vigilance to safeguard Trust resources.

e) Education, Training and Research Committee:

The Committee reviewed progress in research, training, and governance. Strong developments were noted in research, including commercial trials such as MOLI and LIBREXIA, a new partnership with BioNTech for cancer immunotherapy, and plans for a hyperacute stroke research centre. These initiatives supported the Trust's ambition to become a leading academic and clinical hub, with financial sustainability driven by increased trial activity and reinvestment. Training compliance improved, with only five non-compliant metrics remaining. However, life support training and compliance among medical and dental staff remained concerns. A new reporting tool and leadership appointments were helping address those issues, and an options appraisal was being developed for the Workforce Committee. The 2024 National Education and Training Survey showed lower response rates and underperformance in bullying, discrimination, and well-being. An action plan was in development, with further triangulation expected in July. The Committee alerted the Board to ongoing non-compliance in key training areas but provided assurance on research progress and improved training oversight. Efforts were underway to improve transparency and accountability in training reporting and action tracking.

Progress was also reported on progress towards University Hospital status, including meetings with the University of Lancashire to expand joint appointments, nine posts were in place, with a tenth under discussion. Concerns were raised about external developers profiting from Trust-originated ideas, with hopes that new governance structures would better protect and monetise future innovations for long-term institutional benefit.

f) Charitable Funds Committee

At the meeting on 17 June 2025, the Charitable Funds Committee reported a strong financial year for both the Lancashire Teaching Hospitals Charity (LTHC) and Baby Beat (BB), with income reaching £732k against a target of £555k. April 2025 income remained on track. Notable grants included £50k from the Trevor Hemmings Foundation and £25k from the Eric Wright Group, supporting initiatives such as a specialist play scheme and a wellbeing garden. While financial management was commended, the Committee highlighted the need to increase unrestricted income to enhance operational flexibility. The Rosemere Cancer Foundation (RCF) also exceeded expectations, raising nearly £1.5 million in 2024–25, with April 2025 income above budget. Successful fundraising events included the Walk in the Dark and the upcoming Angkor Wat trek. The Committee

approved funding for cancer patient accommodation and chemotherapy unit improvements and emphasised the importance of public relations to maintain transparency and donor confidence.

60/25 NHS 10 Year Plan Update

The Chief Strategy and Improvement Officer attended to present this item.

It was confirmed that the NHS Long Term Plan had been launched and was being actively reviewed. The Trust was in the process of finalising its strategy to ensure alignment with the plan's vision. Work was underway to map local delivery expectations to the strategic framework, building on a previously drafted version that had been deferred to accommodate the new national direction. Three major shifts were highlighted: transitioning services from hospital to community settings, shifting focus from sickness to prevention, and moving from analogue to digital systems. Collaborative efforts were ongoing with local partners to support these changes. Assurance was given that the strategy would incorporate feedback from previous staff and stakeholder engagement sessions, ensuring continuity with earlier input and avoiding a complete restart of the planning process.

It was noted for the Council of Governors that communications regarding the NHS 10-Year Plan were centrally controlled, meaning that public messaging was managed by a national communications team. That sometimes limited the ability to respond fully to public queries about the plan. Alongside the plan, a significant restructure of the Integrated Care Board (ICB) was underway, involving a reduction in staffing from approximately 900 to 400 and the transfer of around 40% of responsibilities to other agencies. This transition was expected to be completed by November. Additionally, the introduction of three-year planning cycles was welcomed as a move away from the traditional one-year planning model. These new plans would focus on areas such as community engagement.

In support of this item, it was agreed that a detailed presentation would be shared with governors after the meeting.

62/25 Annual Members' Meeting

The Trust's Annual Members Meeting (AMM) was scheduled for Thursday 25 September 2025 at 2pm. The meeting, held within nine months of the financial year's end, would present the previous year's annual accounts and provide an overview of the Trust's activities. It would also serve as a platform for elected Governors to be held to account by their electorate. Council was therefore requested to identify appropriate volunteers to present on its behalf at the event.

The timing of the meeting was discussed, with a suggestion raised about whether 2pm was the most suitable time. It was suggested anecdotally that previous meetings held in the evening had seen better attendance. However, it was acknowledged that the current timing had been chosen following lower attendance at earlier sessions held in the evening. The improved venue for this year's meeting was highlighted, and it was agreed to maintain the 2pm slot with increased promotion of the event.

63/25 Process for the Council Effectiveness Review

Council considered the report outlining the establishment of an annual Council effectiveness review process. It was intended that this would build on the recent one to one conversations undertaken by the new Senior Independent Director with governors to determine a set of KPIs against which Council would self-assess for 2025-2026 in March 2026. Thereafter an annual review in March would self-assess against prior year and set KPIs for the forthcoming year. For the current year, the Council was advised to undertake a self-assessment process. The KPIs would be set as part of the planned workshop for Council on 8 August.

67/25 Items for information

The following reports had been circulated with the agenda for information:

(i) Single Improvement Plan
(ii) Governor Opportunities Summary
(iii) Governor Issues Report
(iv) Minutes of Governor Subgroups:
- Care and Safety Subgroup – 12 May 2025
- Membership Subgroup – 5 June 2025
- Chairs, Deputy Chairs and Lead Governor – 1 July 2025

68/25 Date, time and venue of next meeting

The next meeting of the Council of Governors will be held on 30 October 2025 at 10.00am in Lecture Room 1, Education Centre 1, Royal Preston Hospital

69/25 Resolution to exclude press and public

RESOLVED THAT press and public be excluded from the meeting.

The meeting concluded at 12.35pm

5. MATTERS ARISING AND ACTION LOG

Information Item | M Thomas | 1.04pm

REFERENCES

Only PDFs are attached

5.0 - Action log (part I) - Council of Governors - 24 July 2025.pdf

Action log: Council of Governors (part I) – 24 July 2025

No outstanding actions from the previous meeting

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update

COMPLETED ACTIONS ***(for information)***

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	60/25	24 July 2025	*NHS 10 Year Plan Update* – A presentation in support of this item on 24 July would be circulated	Chief Strategy and Improvement Officer/CA Team	30 October 2025	**Complete:** presentation was circulated on 4 August 2025.

6. CHAIRMAN AND CHIEF EXECUTIVE'S OPENING REMARKS

Information Item | M Thomas / S Nicholls | 1.05pm

Verbal

7. NOMINATION OF LANCASHIRE COUNTY COUNCIL APPOINTED GOVERNOR

Decision Item | J Foote | 1.15pm

REFERENCES

Only PDFs are attached

7.0 - Appointed Governor for LCC Oct 2025.pdf

Council of Governors Report

LCC Appointed Governor						
Report to:	Council of Governors		**Date:**	30 October 2025		
Report of:	Director of Corporate Affairs		**Prepared by:**	J Wiseman		
Part I	✓		**Part II**			
For assurance	☐	**For decision**	☒	**For information**	☐	

Executive Summary:

The purpose of this report is to update the Council of Governors on the formal notification from Lancashire County Council regarding the nomination of Councillor Daniel Matchett. This nomination comes as a replacement for Councillor Eddie Pope who has served diligently.

It is recommended that the Council of Governors approve the appointment of Councillor Daniel Matchett as the appointed governor for Lancashire County Council.

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

None

8. BOARD COMMITTEE CHAIRS' REPORTS

Other | Non-Executive Directors | 1.20pm

Item for Assurance

REFERENCES

Only PDFs are attached

8.0 - Board Committee Chairs' Report - CoG Oct 2025.pdf

Board Committee Chairs' Reports

PURPOSE OF THE PAPER:

Council has a statutory responsibility to hold the Board of Directors to account, via the Non-Executive Directors (NEDs), for the performance of the Trust.

This report requires all assurance committee chairs to present to Council. This allows for a greater degree of understanding of the work of Non-Executive Directors committees. The detail contained in the report is not a definitive list of all matters considered, but an assurance provided by the Chairs as NEDs on what they consider to be the matters currently of importance. Sometimes an item may also appear on the agenda for Council as a substantive item (e.g. the Single Improvement Plan). Where this occurs the Committee Chairs will contribute to the debate at that point, rather than duplicating the matter in their own report.

To provide the Council of Governors with assurance that the Board of Directors is ensuring the effective, efficient, and economic provision of services.

ACTION REQUIRED BY THE COUNCIL OF GOVERNORS:

To receive the report and consider the assurance available from this performance assurance report.

Introduction

The NHS Act (2006), as amended, places a duty on the Council of Governors to hold the Board of Directors to account, via the Non-Executive Directors (NEDs), for the performance of the Trust.

Non-Executive Director Assurance

The Board of Directors has in place a Board Assurance Framework (BAF) in which it identifies the key risks to the Trust meeting its strategic objectives.

The oversight and scrutiny of the risks to achieving the strategic objectives, are delegated to Committees of the Board for scrutiny and to gain assurance that the risks are being addressed.

Update from Committee Chairs

This report will continue to ensure that governors are provided with updates from any meetings that have taken place since the last Council meeting.

The narrative below provides an analysis from each of the Trust Committees and sets out the assurance that each Committee of the Board is able to provide to the Council of Governors.

Safety and Quality Committee

Chair: Karen Deeny

NED Analysis:

At meetings held on 25 July, 29 August and 26 September, the Safety and Quality Committee maintained oversight of principal risks, including patient experience within urgent and emergency care, rates of infection, and health inequalities. Risk scores remained stable, with targeted actions and ongoing monitoring in place. The Committee received comprehensive dashboard reports, confirming safe staffing levels across adult inpatient areas and noting improvements in recruitment, training, and workforce initiatives. Challenges persisted in emergency department flow, boarding, and patient experience, prompting renewed focus and operational adjustments.

Maternity and neonatal services continued to meet national standards, with progress in recruitment and compliance with safe staffing assessments. The Committee acknowledged pressures in obstetric rotas and theatre capacity, escalating concerns for further review and business case development. Children and young people's services demonstrated improvements in safety, incident reduction, and patient experience, with staffing adjusted to meet seasonal acuity and operational pressures. The Committee recognised sustained efforts to enhance service quality and responsiveness.

Progress against the Health Improvement Plan was noted, with positive trends in access for deprived groups and reductions in missed appointments. Data integration and dashboard development remained priorities for embedding health inequalities into routine operations. Medical staffing reports highlighted reductions in safety concerns and agency usage, with mortality rates below national averages. The Committee supported proposals for annual reporting and cross-referencing with Workforce committee.

Regulatory engagement and audit activity continued, with positive outcomes from inspections and assurance of compliance with national standards. The Committee received updates on incident management, clinical harm reviews, and improvement actions, confirming robust governance arrangements. Items for escalation included alerts regarding never events, maternity theatre capacity, and children in unsuitable settings, alongside assurance of ongoing improvement work and compliance with statutory requirements.

The Committee reflected on the transparency and scrutiny of reports received, noting that negative escalations, timeframes, and trajectories would be included in future updates. The Committee reaffirmed its commitment to delivering excellent care with compassion, underpinned by rigorous oversight and continuous improvement.

Finance and Performance Committee

Chair: John Schorah

NED Analysis:

At meetings held on 22 July, 26 August and 23 September, the Finance and Performance Committee met to review the organisation's financial position, operational performance, and strategic risks. Throughout this period, the Committee maintained oversight of principal risks, including urgent and emergency care, cancer care, planned care, and the financial plan, with risk scores remaining largely static and some operational risks newly identified or increased. The Trust's financial position was consistently challenged by under-delivery of the Waste Reduction Programme, additional costs from industrial action, and ongoing cash constraints, resulting in deficits that exceeded planned targets. Mitigation measures included engagement with NHS England, delayed capital expenditure, and management of supplier payments, with cash support requests submitted and partially fulfilled.

The Committee noted improvements in agency spend and workforce metrics, though bank pay increased and headcount reductions fell short of targets. Delivery of savings schemes was below expectations, prompting a root-and-branch analysis and a mid-year refresh of the Waste Reduction Programme. The Committee emphasised the importance of maintaining focus on recurrent savings and aligning projected outcomes with actual delivery, while recognising the need for strategic decisions to ensure financial sustainability.

Operational performance was reviewed across urgent and emergency care, referral to treatment, cancer, diagnostics, and system-wide initiatives. While some improvements were noted, key targets were consistently missed or at risk, with persistent breaches in waiting times and capacity constraints affecting patient flow and outcomes. The Committee acknowledged the fragility of performance and the need to maintain momentum, with further analysis requested to identify contributors and detractors to financial performance.

Planning controls and progress against the Single Improvement Plan were monitored, with most milestones on track and positive shifts observed, though concerns remained regarding workforce and operational pressures. The Committee recognised the complexity of planning amid uncertainties and emphasised the importance of coordinated efforts across finance, workforce, and quality. The implications of the newly published NHS 10-Year Health Plan and draft Planning Framework were discussed, highlighting the shift towards community-based care, digital transformation, and prevention-focused services, with financial discipline and multi-year strategic planning required.

The Committee received updates on subsidiary operations, contract performance, and emergency preparedness, resilience, and response standards, confirming substantial compliance and ongoing improvement actions. Winter planning was prioritised, with mitigation schemes mobilised to manage anticipated surges in demand and maintain patient safety and flow. The Committee reflected on the importance of transparency, challenge, and continuous improvement, agreeing to adopt concise reporting formats and maintain rigorous oversight of underperformance and strategic risks.

Workforce Committee

Chair: Adrian Leather

NED Analysis:

The Workforce Committee met on 8 July and 9 September to review strategic risks, workforce trends, and organisational development, maintaining oversight of principal risks including reliance on temporary medical staff, staff experience with a focus on underrepresented groups, and management of staff absence. Risk scores remained largely unchanged, though operational high risks fluctuated, with improvements noted in areas such as radiotherapy engineering and junior medical cover. The Committee highlighted ongoing challenges with workforce information team capacity, which impacted data collection and reporting, and agreed to escalate this issue to the Board for timely resolution. Vacancy rates remained high but stable, reflecting posts held to support financial recovery, while agency usage declined and bank usage increased, partly due to industrial action. Job planning completion rates improved, and compliance with appraisal and mandatory training remained high, though some areas required further attention. Sickness absence rates reduced for long-term cases, but short-term absence increased, necessitating additional focus and intervention.

The Committee received updates on workforce reduction targets, noting progress in reducing agency usage and substantive staff numbers, but also recognising the gap between planned and actual reductions, influenced by increased bank staff usage and operational pressures. Reports on fragile services identified persistent recruitment challenges and reliance on temporary staff in several clinical areas, with ongoing monitoring and cross-divisional actions in place. Incidents of violence and aggression affecting staff continued to rise, particularly in certain departments, prompting enhanced security measures, training, and support initiatives. The

Committee endorsed the development of improvement plans and agreed to advise the Board of the risks identified.

Positive developments were reported in medical appraisal and revalidation, with 100% completion for eligible doctors and improvements in processes and support. The onboarding and retention strategy showed a continued positive trend in voluntary turnover rates, with enhanced support for new starters and targeted retention workstreams. The Committee acknowledged the cultural impact of these initiatives, particularly within specific divisions, and discussed the importance of understanding reasons for staff retention and turnover. The Committee also reviewed progress on the social value strategy, health and wellbeing initiatives, and cultural development, noting alignment with broader organisational goals and the need for continued investment and communication. Exception reporting and junior doctor welfare were monitored, with ongoing action plans to address staffing concerns and rota gaps.

Throughout the meetings, the Committee emphasised the importance of divisional accountability, data granularity, and effective connectivity across committees, recognising the need to balance financial, performance, safety, and quality considerations.

Audit Committee

Chair: Tim Wheeler

NED Analysis:

The Audit Committee met on 24 June and 24 September 2025 to review the organisation's internal and external audit activities, risk management, financial accounts, and governance processes. Across both meetings, the Committee received updates on the progress of the internal audit plan, noting substantial assurance in areas such as mandatory training and patient safety incident response, while highlighting limited assurance in health and safety governance, which prompted the development of a targeted improvement plan. The Committee discussed the outcomes of audits on data quality, waiting list management, and grip and control, acknowledging the need for enhanced validation, updated policies, and improved oversight. Progress on implementing audit recommendations was monitored, with most actions completed or in progress and revised deadlines set for outstanding items.

External audit reports were presented, including the ISA260 and Annual Auditors Report, which identified improvements in financial sustainability and procurement, though early-year weaknesses in financial performance were noted. The draft annual accounts reflected a significant deficit, with operating income and expenses detailed, and the management representation letter was approved for submission. The Annual Report outlined strategic developments, operational challenges, and governance enhancements, with the Committee recommending its approval to the Board. The Committee also reviewed the organisation's compliance with the Data Security and Protection Toolkit, noting a status of 'standards not met' due to national framework changes, and approved the submission of an improvement plan.

Risk management was a key focus, with evidence of progress in KPIs, thematic reviews, and the rollout of new training, though some long-standing operational risks persisted. The Committee received updates on procurement activity, single tender waivers, and losses and special payments, noting improvements in control measures and adherence to policy. Cyber security risks were discussed, including the need for system upgrades and multi-factor authentication, with plans in place to address vulnerabilities. Clinical audit activity was robust, with high compliance rates and ongoing improvement actions in response to national standards. The management of procedural documents was reviewed, with process improvements implemented to strengthen governance and accountability.

Throughout the meetings, the Committee emphasised the importance of sustaining improvements, integrating divisional performance metrics, and maintaining transparency in reporting. The procurement process for external auditors was agreed to follow a mini competition under the NHS national framework, ensuring compliance and efficiency. The Committee reflected on the positive developments and ongoing challenges, reaffirming its commitment to robust oversight, effective risk management, and continuous improvement in governance and assurance processes.

Education, Training and Research Committee

Chair: StJohn Crean

NED Analysis:

The Education, Training and Research Committee met on 10 June and 12 August 2025 to review strategic risks, educational performance, and research progress across the organisation. Oversight was maintained on principal risks including the experience of resident doctors, compliance with core skills training and appraisals, and research capacity to support progress towards University Hospital status. Risk scores remained unchanged, though positive assurances suggested a reduction in risk levels may be appropriate, particularly for resident doctor experience. The Committee received divisional self-assessment summaries, identifying areas of good practice and persistent challenges, such as maintaining supernumerary status for students, cultural barriers, and compliance with mandatory training. Action plans and targeted interventions were in place to address these issues, with improvements noted in medical staffing, induction programmes, and support for trainees. The impact of workplace culture on education was explored, especially in maternity and paediatrics, with comprehensive work undertaken to foster positive environments and improve team dynamics.

Core skills and mandated training compliance continued to improve, with the Trust meeting or exceeding targets in nearly all metrics, although pockets of non-compliance persisted among medical and dental staff. Initiatives such as personalised reminders, enhanced reporting, and recognition of prior learning were implemented to address these gaps. The Committee discussed the accuracy of training metrics and the importance of robust appraisal processes, with legal considerations confirmed for enforcement. The General Medical Council National Training Survey results showed marked improvement, with overall satisfaction rising above the national average for the first time in over four years. Areas for further attention included workload, rota design, facilities, and clinical supervision out of hours.

The education and training strategy was being refreshed to focus on widening participation, university partnerships, and career pathways, with achievements in apprenticeship provision and regional recognition. The research department continued to progress towards University Hospital status, launching new commercial trials, securing joint academic appointments, and maintaining high standards in governance and quality. Financial performance in education and training showed a net surplus, with ongoing monitoring of risks related to funding and tariff uplifts.

The Committee reflected on the importance of clear communication, proactive compliance monitoring, and collaborative approaches to address challenges.

Charitable Funds Committee

Chair: Tim Ballard

NED Analysis:

At the meeting on 16 September, the Charitable Funds Committee convened to review the financial and operational performance of the Lancashire Teaching Hospitals Charity and the Rosemere Cancer Foundation. Both charities began the financial year ahead of target, with strong fundraising outcomes supported by grants, donations, and community events. Expenditure was managed prudently, and staffing changes were accommodated without disruption.

The Committee approved significant funding applications, including the transformation of a courtyard garden at Royal Preston Hospital to support bereaved families and staff, and a research project aimed at improving early identification and prevention of anal cancer.

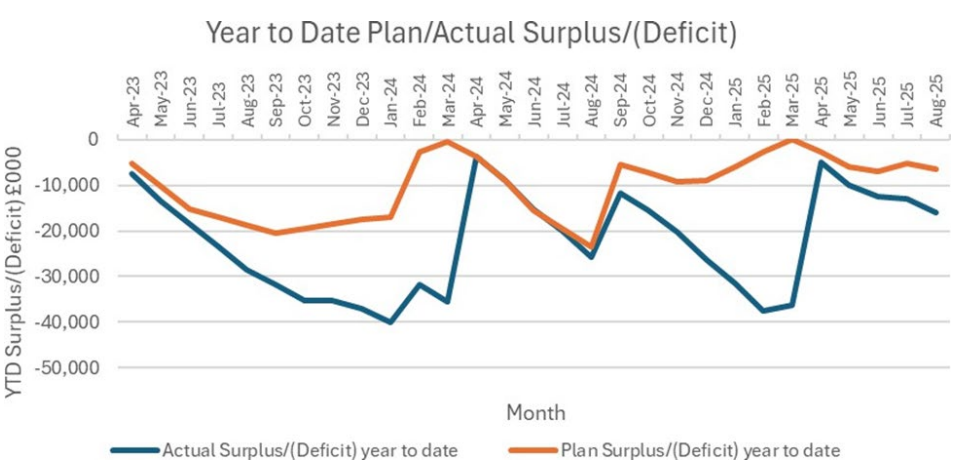
Financial reports indicated an increase in combined charity funds and a healthy balance after commitments, with income and expenditure closely monitored. Amendments to legacy income recognition practices were made to ensure compliance with auditor recommendations and charity accounting standards. Annual reports and accounts for both charities were approved, subject to minor presentational amendments, and both received unqualified audit opinions. The Committee also ratified the updated investment and reserves policy, confirming continued adherence to ethical standards and best practice.

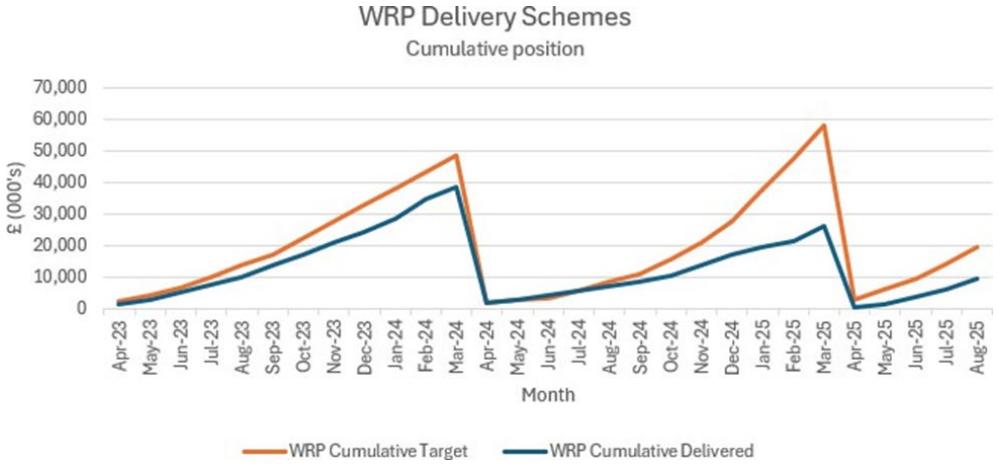
Appendix 1 – Governor Dashboard

Lancashire Teaching Hospitals
NHS Foundation Trust

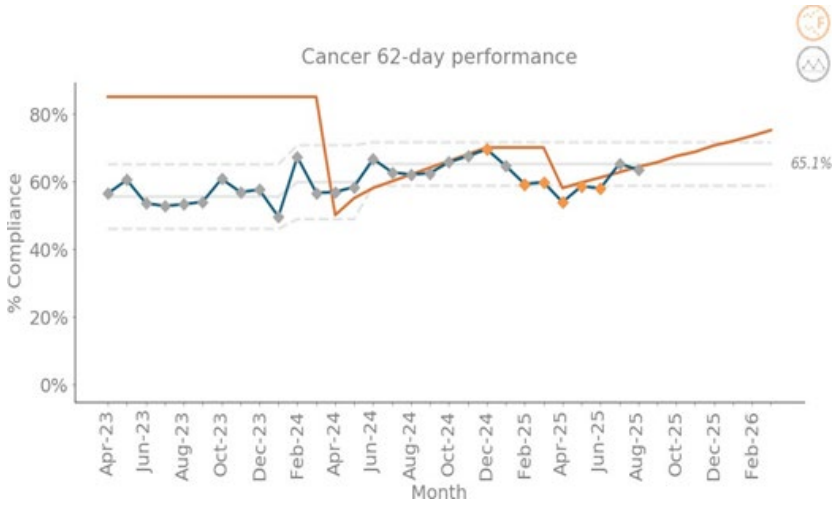
Finance and Performance

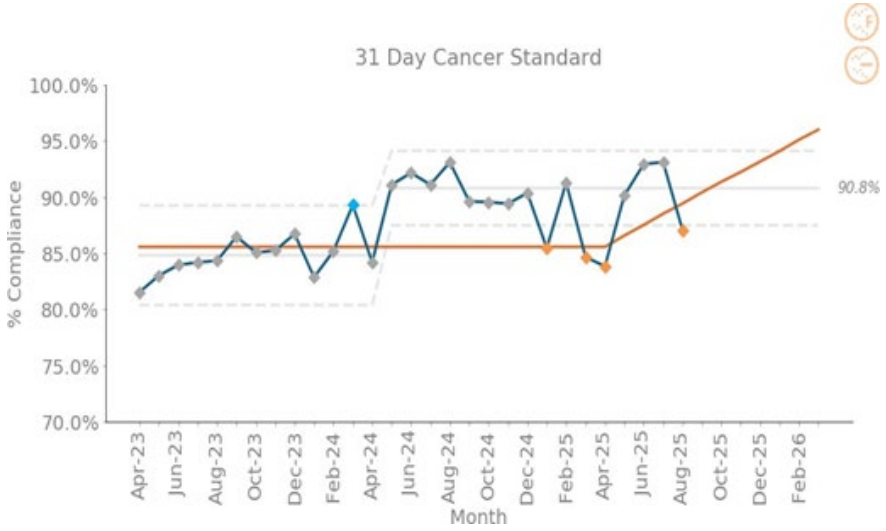
Productivity Assurance

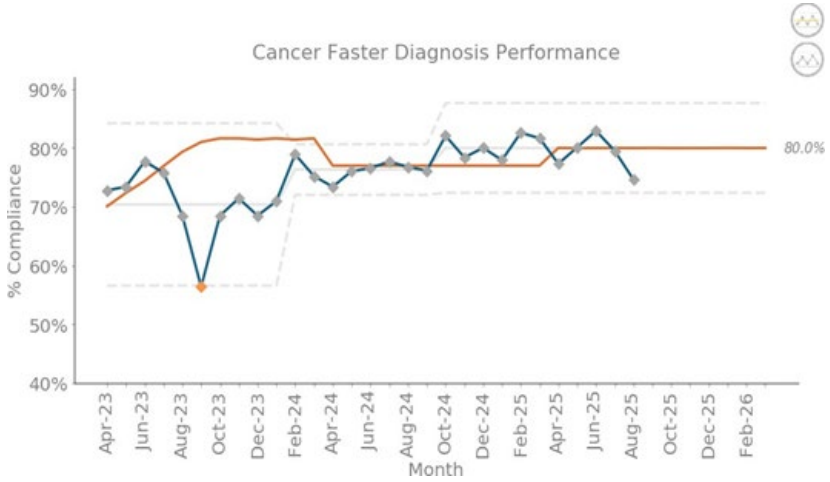




Cancer Assurance

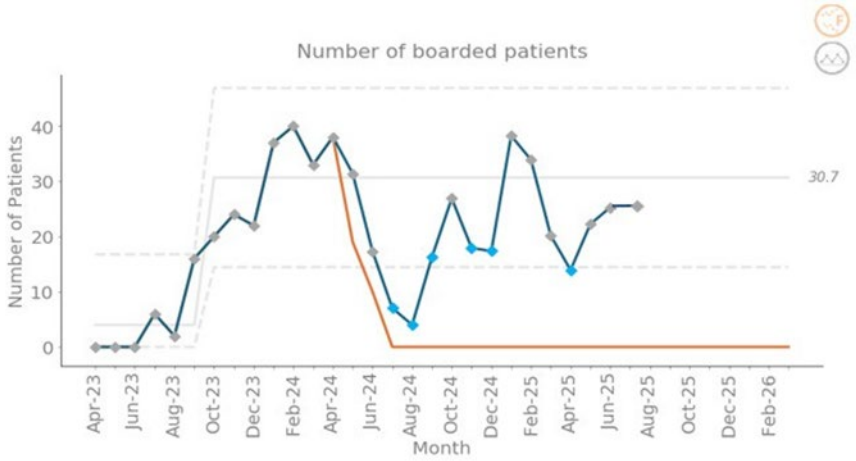




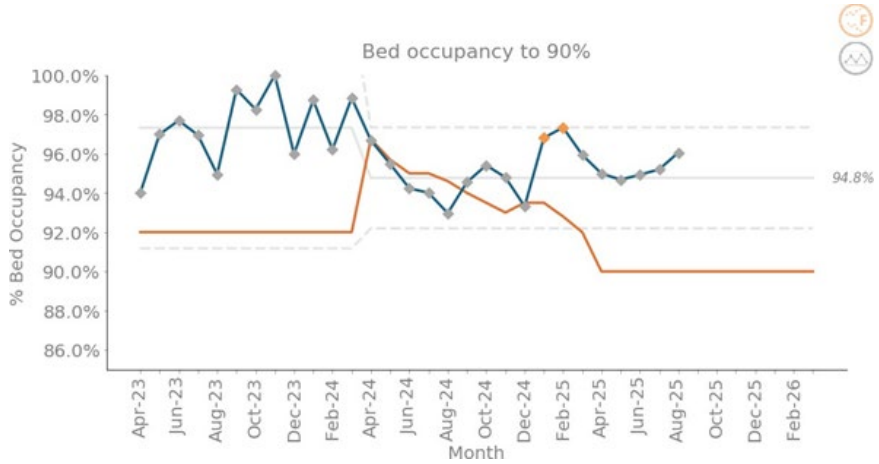


Lancashire Teaching Hospitals
NHS Foundation Trust

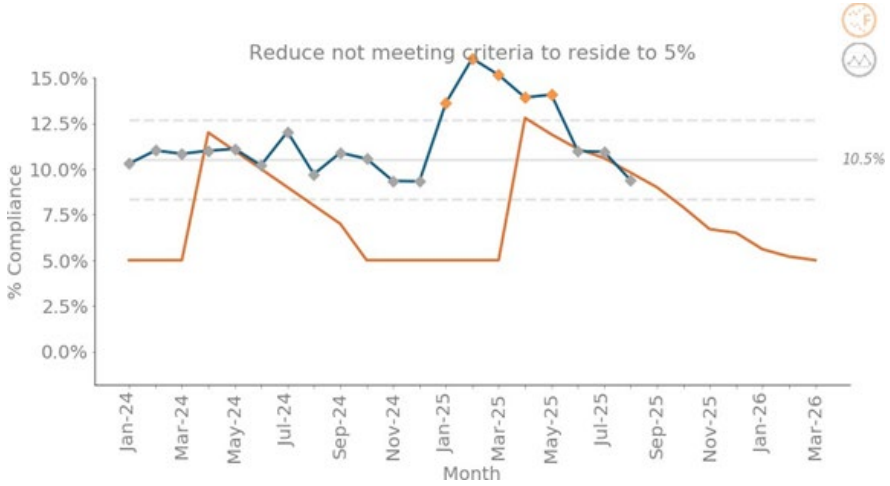
UEC Assurance



Latest
23
Variance Type
Normal variation - no recent change
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation

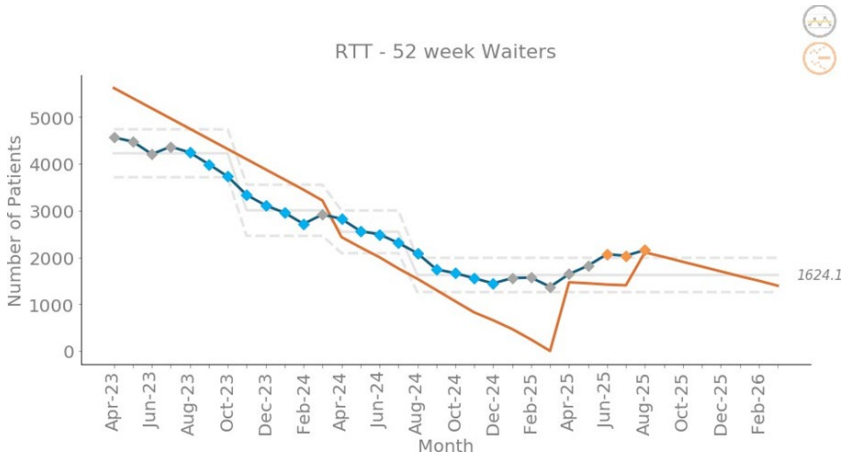


Latest
96.1%
Variance Type
Normal variation - no recent change
Mar 26 Target
90.0%
Target Achievement
Will consistently fail the target within expected variation

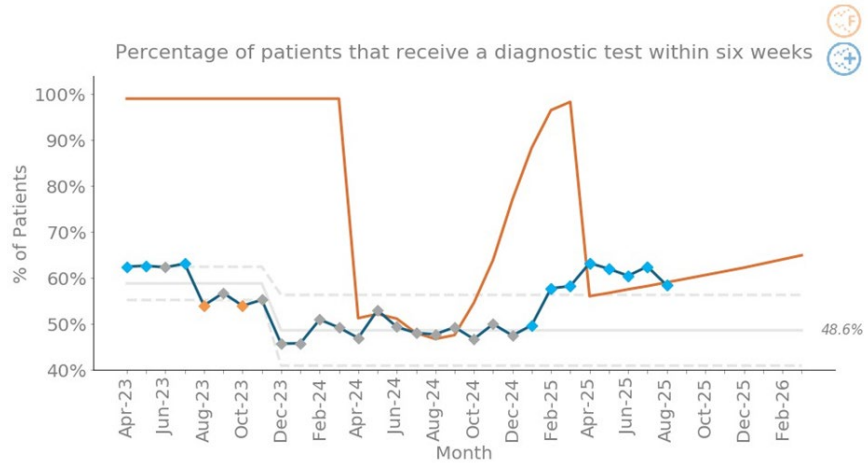


Latest
9.4%
Variance Type
Normal variation - no recent change
Mar 26 Target
5%
Target Achievement
Will consistently fail the target within expected variation

Performance Elective Care Assurance



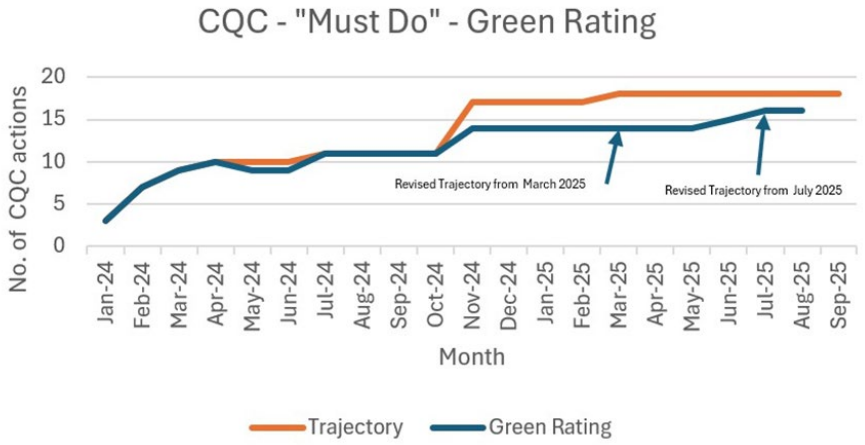
Latest
58.4%
Variance Type
Recent positive pattern in the data
Mar 26 Target
65.0%
Target Achievement
Will consistently fail the target within expected variation



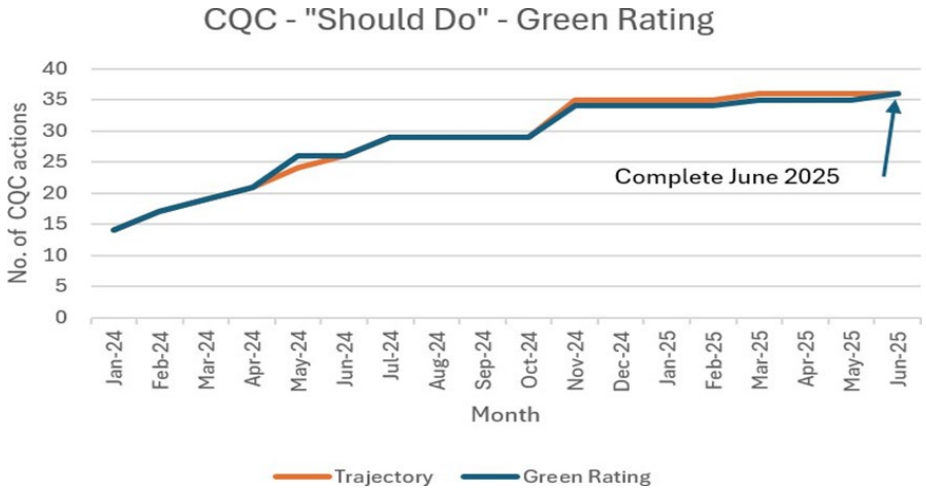
Latest
2158
Variance Type
Recent concerning pattern in the data
Mar 26 Target
1395
Target Achievement
Could both pass or fail target within expected variation

Safety and Quality

CQC Assurance

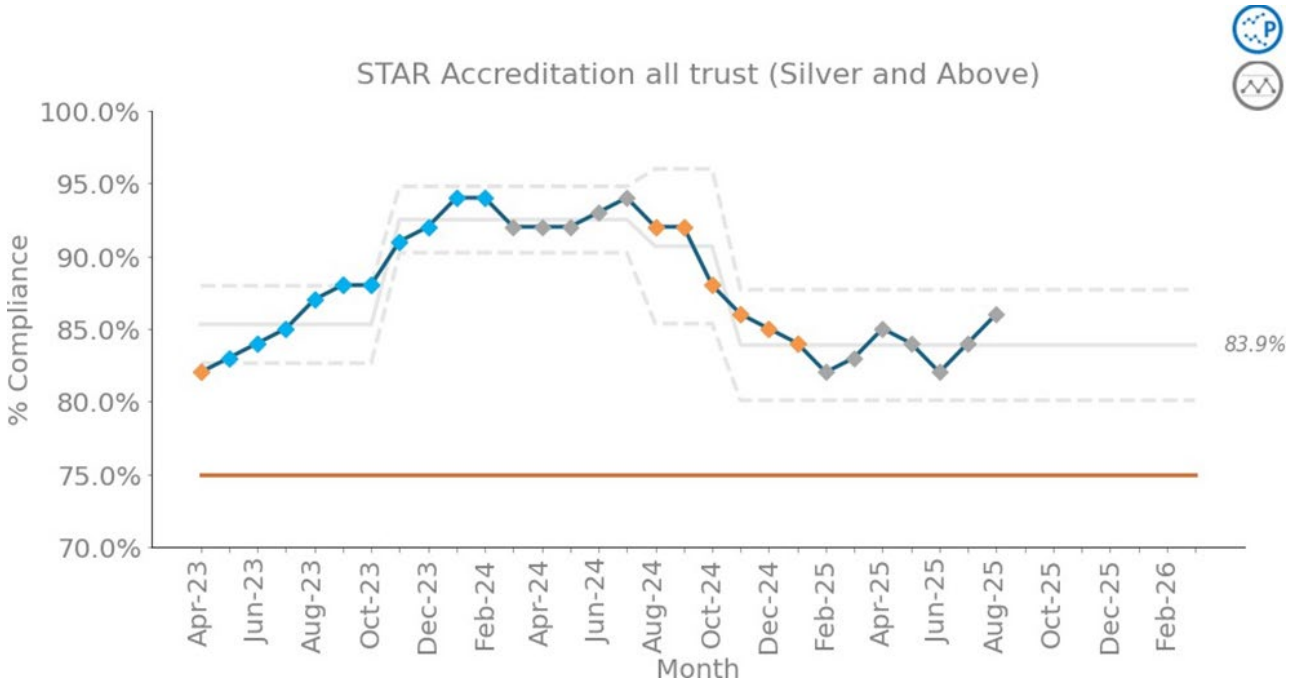


Latest
16
Month Target
16
Sept-25 Target
18



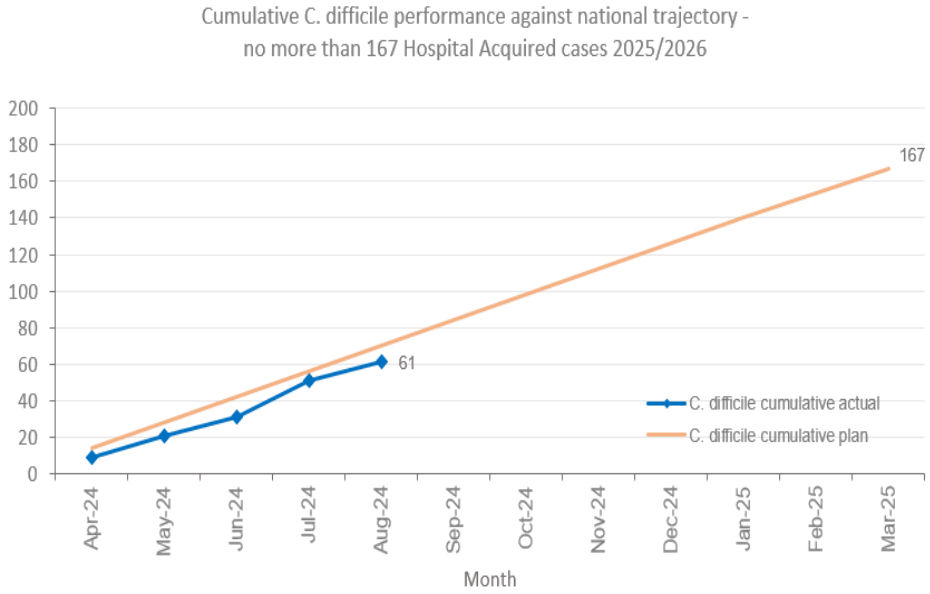
Latest
36
Month Target
36
June-25 Target
36

STAR Accreditation



Latest
86.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

C. Difficile Improvement Programme Assurance

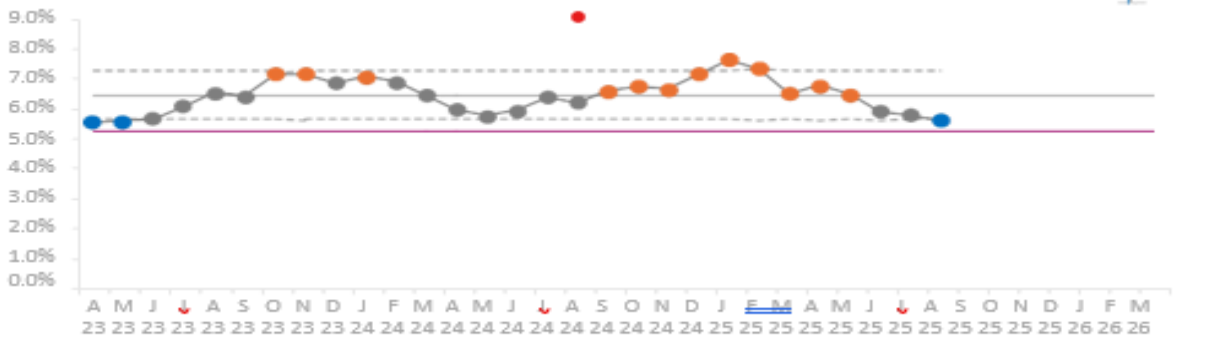


Latest
10
Variance Type
Normal variation - no recent change
Mar-26 Target
13
Target Achievement
Could both pass or fail target within expected variation

Lancashire Teaching Hospitals
NHS Foundation Trust

Workforce

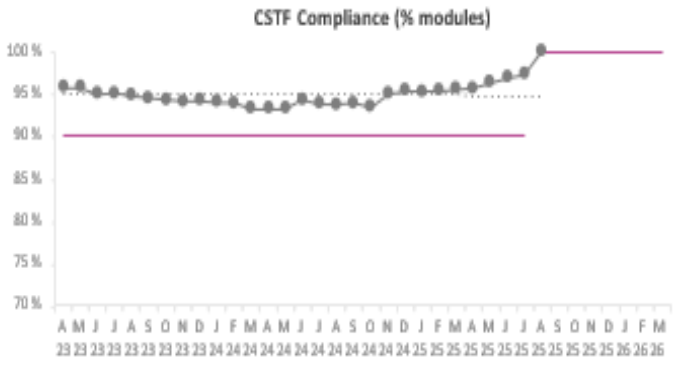
Sickness Absence Assurance



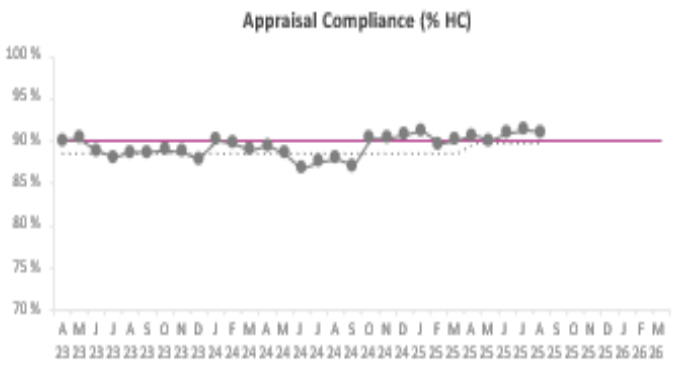
Latest
5.56%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 5.22%
Target Achievement
Will consistently fail the target within expected variation

Lancashire Teaching Hospitals
NHS Foundation Trust

Training Compliance Assurance



Latest
100.00%
Variance Type
Mar 26 Target
100% of metrics at 90%
Target Achievement



Latest
91.24%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

9. UPDATE FROM CARE AND SAFETY SUBGROUP

Information Item | J Miller | 1.40pm

Verbal

10. UPDATE FROM MEMBERSHIP SUBGROUP

Information Item | S Brennan | 1.50pm

Verbal

11. SAFETY, QUALITY, WORKFORCE AND PERFORMANCE

11.1 INFECTION PREVENTION AND CONTROL ANNUAL REPORT

Other | S Morrison | 2.00pm

Item for Assurance

REFERENCES

Only PDFs are attached

11.1 - Infection Prevention and Control Annual plan including Clostridium Difficile Deep Dive.pdf

Council of Governors

Infection Prevention and Control (IPC) Annual Report 2024/2025

Report to:	Council of Governors	**Date:**	30th October 2025
Report of:	Chief Nursing Officer	**Prepared by:**	Director of Infection Prevention and Control (DIPC) Dr D Orr IPC Matron S Marsh

Purpose of Report

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

Executive Summary:

The purpose of this report is to provide the Council of Governors with the Infection Prevention and Control Annual report that has been scrutinized by the Safety and Quality committee and presented to the Board of Directors. The purpose of the report is to provide an overview of the progress made against the Infection Prevention and Control plan for 2024/2025 and assure the Safety and Quality Committee on the Trust's performance against key areas of Infection Prevention and Control (IPC).

Throughout the 2024/2025 period, there were high levels of community transmission of Norovirus and Influenza with subsequent spread in hospitals. This led to sustained operational pressures on the National Health Service (NHS).

In 2024/2025 the summary points of the IPC speciality include:

- There is stable leadership of IPC practice with Dr David Orr holding the position of Director of Infection Prevention and Control (DIPC), Dr Robert Shorten being appointed as the associate DIPC in December 2024, and Sarah Marsh providing Nursing Leadership as the Infection Prevention and Control Matron
- There were 0 hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia case.
- The *Clostridioides difficile (C. difficile*/CDI) objective was achieved, with 192 cases reported— 7 below the allocated trajectory by NHS England of 199. This marks the first time the trajectory has been met since 2019/2020, but it does follow an increase in the objective that was set from 2023/2024 of 132 cases. Overall, there has been a reduction in cases as 2023/2024 resulted in 203 cases. Nevertheless, *C. difficile* continues to present a significant risk to the organisation and incidence rates remain the second highest in the Northwest with a rate per 1000 bed days of 62.3. Hence, it is a principle risk under the new Trust Board Assurance Framework (BAF).
- The Objective for Gram - Negative Bacteraemia was exceeded by 10 cases with 109 cases out of an objective of 99.
- The Influenza season was sustained over 3 months from November 2024 to January 2025 which reflected the National picture.
- Norovirus - The year 2024/2025 saw a very high number of Confirmed Norovirus Outbreaks across the Trust and these had a significant operational impact. However, this matched the current National picture with increased spread of the new variant of Norovirus (GII.17)

- The introduction and implementation of the Patient Safety Incident Response Framework (PSIRF) focussing on system learning and advocating that time should be spent on value added improvement actions rather than investigating individual incidents that draw a conclusion of no new learning.
- The National Standards of Healthcare Cleanliness (2025) have not been fully implemented across all clinical areas within the Trust. Currently 15 wards are compliant within the existing resource of domestic services. Further roll out required further investment and a Business Case was produced that has now been approved by the Board of Directors. A phasing implementation plan for all other high and very high-risk areas will be implemented during the 2025/2026 period.
- There is increased assurance of IPC and cleaning processes via STAR.
- The IPC Team are working with Estates to improve completion of remedial work requests that have an IPC impact.
- All Divisions are achieving their target of over 90% compliance with IPC Mandatory training, and this is consistent throughout the year.
- The Trust has remained >90% compliant with documented indication on the drug chart and documented review within 72hrs for the full year. Compliance with Antimicrobial choice in line with guidelines or recommended by Microbiology was also >90% for the most quarters whilst in Q3 it was 85%.
- Water Safety – The Trust Water Safety Plan remains in place, and this supports the capital development programme. Hydrop, who provide the Trust's Authorising Engineer for Water have updated the Trust Water Safety Plan in line with new/revised guidance. The Authorising Engineer conducted the water safety audit 10th and 11th September 2024 in line with Health Technical Memoranda (HTM) 04. Overall, the audit outcome is positive considering the ageing Estate, and an action plan has been implemented to progress the identified improvement work. In 2024 /2025 the targeted augmented care areas were reviewed with the DIPC and Infection Prevention Control Matron to ensure the testing regimen is aligned with the clinical services being provided.
- Throughout the reporting period, the Sterile Services department demonstrated diligence in maintaining compliance with the HTM01-01 standards and ISO 13485:2016 Quality Management System. Staffing within the Estates Team is recognised as a risk with a score of 12 and has impacted on the frequency of water safety group meetings and reports. This requires improvement in 2025/26.
- Ventilation – The Estates services department continue to implement the relevant guidance within HTM 03 to control the risk of airborne particulate transmission despite challenges due to vacancies within the team and the trust financial position. The Estates team also continue to engage and independent authorising engineers to ensure new mechanical ventilation systems comply with new HTM guidance as well as identifying priorities for the 2025/26 backlog capital programme.
- Decontamination - The Trust decontamination lead has limited capacity to fulfil all the requirements of the role. Reports are provided on a quarterly basis to IPCC for assurance. This represents a risk for the Trust and discussions are underway to mitigate gaps and this will be added to the risk register.
- Waste - The Trust is in the process of implementing the colour coding for clinical waste across our sites. This follows good practice. A new clinical waste contract has been negotiated working with other Trusts in the local Integrated Care Board (ICB), providing Lancashire Teaching Hospitals with some cost savings. The IPC Continue to support the waste manager by attending monthly waste management meetings and continue to contribute to waste management initiatives.
- Research – Primel Study - In October/November 2024, the IPC team led in the implementation of a research study investigating a new hand hygiene product – Primel® Active Hand Coating (PAHC).

The report contains an update on the actions delivered in the 2024/25 IPC plan, the majority of which were completed but where a delay has occurred the reason for this is given alongside the plan for how this is being addressed. This closes the IPC plan for 2024/25 and presents the 2025/2026 IPC plan for approval.

It is recommended that:

- The Council of Governors note the contents of the Annual report noting the progress against the 2024/25 Annual Plan in Appendix 1 and the approved IPC Annual Plan for 2025/2026 (Appendix 2).

Appendix 1 – IPC 2024/25 Annual plan
Appendix 2 – IPC 2025/26 Annual plan
Appendix 3 – *C. difficile* Improvement plan
Appendix 4 – Infection, Prevention and Control Structure
Appendix 5 – Community of Practice Agenda October 2024

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

Infection Prevention and Control Committee

1. Introduction

The purpose of this report is to provide the Council of Governors with the Infection Prevention and Control Annual report that has been scrutinized by the Safety and Quality committee and presented to the Board of Directors.

The purpose of this report is to provide an overview of the progress made against the Infection Prevention and Control Annual plan for 2024/2025 and update the Safety and Quality committee on the Trust's performance against the Annual Objective for Methicillin-Resistant Staphylococcus aureus (MRSA) bloodstream infection and *Clostridioides difficile* infection (*C. difficile*/CDI).

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals (LTHTR). The IPC Team continues to work closely with other providers across the Health Economy. Dr David Orr, a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Matron for Infection Prevention and Control, Sarah Marsh, is the Senior Nursing Lead. The DIPC is supported by the Deputy Chief Nursing Officer, Catherine Gregory and the Associate Director of Infection Prevention and Control (ADIPC), Dr Robert Shorten, the IPC Specialist Nurses, and Consultant Microbiologists.

Hospitals across the UK faced significant challenges during 2024/25 driven by a substantial increase in inpatients admissions. This led to overcrowding in Emergency Departments and Assessment Units, as well as an increased reliance on boarding practices (where patients are placed in additional temporary or non-designated clinical areas due to a lack of available beds). These pressures were further compounded by a rise in infection rates following the COVID-19 pandemic.

In November 2023, the Trust implemented the Patient Safety Incident Response Framework (PSIRF), which emphasises system-wide learning and prioritises meaningful improvement actions over the investigation of individual incidents that yield limited or no new insights. PSIRF represents a shift away from the traditional, linear 'one-size-fits-all' Root Cause Analysis (RCA) model, advocating instead for a flexible, system-based approach to incident response. The framework enables organisations to better allocate resources toward initiatives that drive patient safety improvements, rather than repeatedly addressing incidents based on subjective harm thresholds that often result in minimal learning."

The implementation of PSIRF across the system provided an opportunity to refocus our approach to infection-related incidents, enabling a more in-depth understanding of the systemic factors contributing to infections. This enhanced perspective supports the identification of meaningful improvements aimed at disrupting the chain of infection transmission. The framework also facilitates the identification of new learning and the dissemination of best practices across the Trust.

This report presents the details of IPC performance at Lancashire Teaching Hospitals Trust (LTHTR) in 2024/2025 with the focus on key IPC issues and includes the 2024/2025 programme which details the completion of improvement actions in line with the ten domains of the Hygiene Code which accompanies the Health and Social Care Act 2022.

The Infection Prevention and Control Annual Plan 2024/2025 is attached for information and closure. The 2024/25 IPC Annual Plan was ambitious, and most actions have been delivered, however, because of unprecedented demand, financial limitations, multiple infections, and staffing levels (both within LTHTR and the Integrated Care Board) there have been some which have been delayed and are carried over to the annual plan 2025/2026. These include:

- 4.3.1 – Using PSIRF principles review any themes and trends identified in Hospital Associated Gram Negative cases

- 4.3.2 - Standardise Continence and Bowel Care services across the ICB
- 4.3.6- Reduce Catheter Associated Urinary Tract Infections
- 6.2.1- To be compliant with the National Standards of Healthcare Cleanliness 2021
- 6.1.1 - Provide monthly reports to IPCC on Water safety

The 2025/2026 Annual Plan (Appendix 2) is attached for approval. This will expand and build on improvements made in 2024/2025 (Appendix 1).

TRUST PERFORMANCE RELATED TO ORGANISMS OF CONCERN

1.1. MRSA Bacteraemia

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of S. *aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some S. *aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant S. *aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for the Trust, and the incidence of MRSA has seen an improvement during the reporting period and comparison to previous data is outlined below:

- In 2022-23 there was 1 incident of hospital onset MRSA bacteraemia and 5 cases of community onset MRSA.
- In 2023-24 there was 1 incident of hospital onset MRSA bacteraemia and 7 cases of community onset MRSA.
- In 2024-25 there has been 0 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.

As of 2024/2025, the investigation process for MRSA Bacteraemia Hospital Acquired case was amended to incorporate PSIRF principles but this has yet to be tested due to no incidents. There were 2 Community cases which were investigated by the Community IPC Team. Neither of these cases acquired their infections at LTHTR.

1.2. *Clostridioides difficile* Infection

Clostridioides difficile (*C. difficile*) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances, strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are elderly and/or immunocompromised; exposed to antibiotics and *C. difficile* from spores within the environment.

NHS England define the report of *C. difficile* Toxin positive cases into the below grouping:

- Hospital Onset Healthcare Associated (HOHA): cases that are detected in the hospital two or more days after admission.
- Community Onset Healthcare Associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
- Community Onset Indeterminate Association (COIA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.

- Community Onset Community Associated (COCA): cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

The National Objective for the Trust encompasses both HOHA and COHA cases.

In 2024/2025 the Trust recorded 192 Hospital Associated cases against an Annual Objective of 199, successfully being within tolerance by 7 cases below the threshold. This marks a positive trend with a reduction in Hospital Associated *C. difficile* cases compared to 2023/2024 total of 203 cases which was set against the previous objective of 121. The 2024/2025 results reflect a 5% reduction in cases, and notably it is the first time the Trust has met its objective and been under Trajectory since 2018.

Figure 1 Performance of *C. difficile* cases against National Trajectory

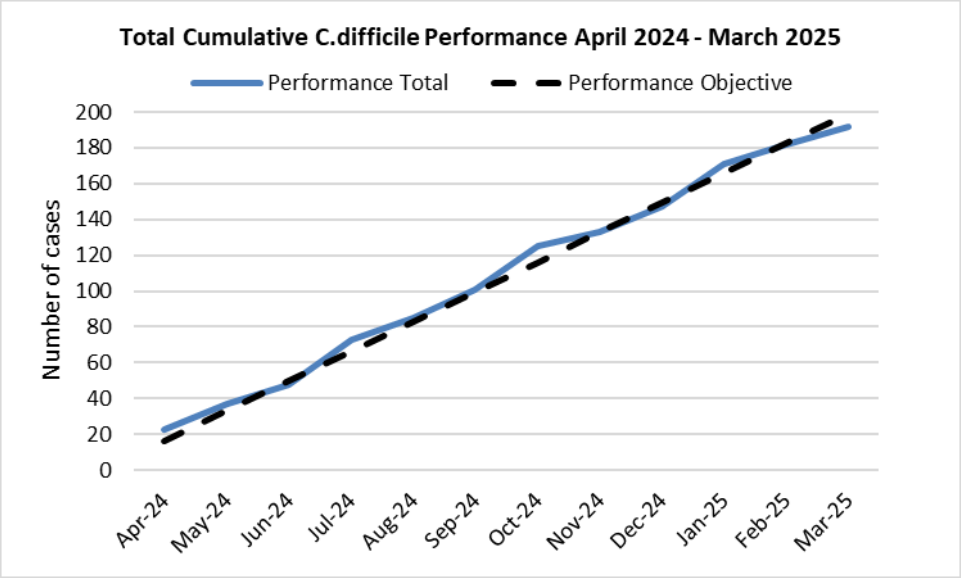
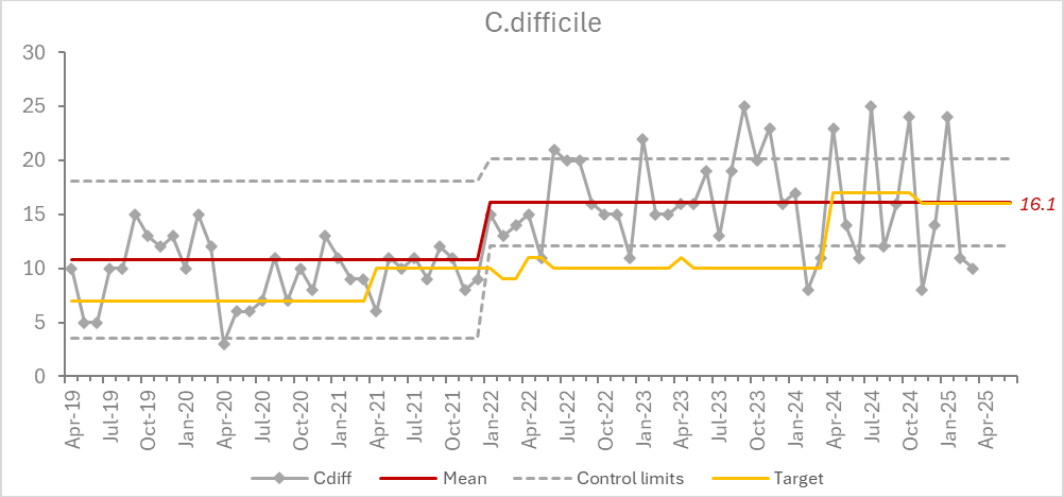


Figure 2 presents a Statistical Process Control (SPC) chart illustrating the monthly trend of Hospital Associated *C. difficile* cases per month from April 2019 to April 2025. A notable increase in cases is evident in 2022, which aligns with a Trust-wide policy change that expanded the definition of diarrhoea to include type 5 stools. This policy adjustment, implemented at the direction of NHS England Regional Leads, led to an approximate 60% increase in testing. Whilst the Trust has now met its National Objective this year (due to an increase in the Nationally set allowance of cases; 199 vs 121 last year), the chart indicates that there has not been a statistically significant reduction in overall *C. difficile* cases.

Figure 2 Hospital Associated *C. difficile* Toxin positive rates per month.



The National and Regional picture

As reported in last year's annual report, there has been a National increase in *C. difficile* Infection and the Northwest is a region with particularly high incidence. However, LTHTR ranks highest of major Trusts in terms of *C. difficile* rate per 100,000 bed days.

Table 1 *C. difficile* incidence and rate per 100,000 bed days – Northwest hospitals April 2024 - March 2025

C. difficile annual tables: cases & rates by Trust

Organisation Name	April 2024 to March 2025	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	13	21.2	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	128	48.3	
BOLTON NHS FOUNDATION TRUST	127	58.6	High (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	83	48.8	High (0.025)
EAST CHESHIRE NHS TRUST	25	22.9	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	96	26.9	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	192	62.3	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	4	7.3	Low (0.001)
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	207	37.3	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	288	35.0	
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	114	25.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	47	27.5	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	63	29.4	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	189	36.4	Low (0.001)
STOCKPORT NHS FOUNDATION TRUST	90	41.2	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	81	50.4	
THE CHRISTIE NHS FOUNDATION TRUST	51	82.5	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	13	39.7	
THE WALTON CENTRE NHS FOUNDATION TRUST	7	14.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	89	43.2	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	90	44.9	Low (0.025)
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	167	64.8	High (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	76	63.4	
North West	2242	40.0	

LTHTR has had particularly high rates of *C. difficile* Infection since the financial year 2022/23 onwards and this led to executive level intervention by the Chief Nursing Officer and the development of a specific *C. difficile* action plan which is monitored through the monthly Infection Prevention and Control Committee and the Estates and Facilities Partnership Board. (Appendix 3)

Main developments during 2024/2025

1. Case made for implementation of the National Standards of Healthcare Cleanliness, 2021 (now updated to include the newly released National Standards of Cleanliness, 2025 released in January).

   The United Kingdom Health Security Agency (UKHSA) field epidemiologists supported Trust IPC leaders to analyse the impact of National Standards of Healthcare Cleanliness compliance (2021) within 15 clinical areas of LTHTR which were included in the first phase of a partial roll-out. This data confirmed that there was a reduction in *C. difficile* infection in the compliant areas. Wards pre the cleanliness standards had a rate of *C. difficile* infection cases of 19.4 per 1000 days and wards post the cleanliness standards had a rate of *C. difficile* cases of 14.4 per 1000 days.

   Using the information obtained from this analysis, a business case was written for full implementation of National Standards of Healthcare Cleanliness which went to Trust Management Board on the 5th of March 2025 and was approved. This involves £747,514 new funding for cleaning at LTHTR and the equivalent of 26 WTE additional posts, implementation being rolled out in a phased manner through 2025 /2026.

2. Roll out of PSIRF and local reviews of *C. difficile* cases.
   In 2024/2025, there was a movement away from Post-infection Reviews for every case of Hospital Onset Hospital Associated *C. difficile* infection, to instead a ward level review with action plan on Datix using pre-defined quality indicators and explanations for non-compliance. These include:
   - Were the patient's prescribed Laxatives discontinued at diagnosis
     - Why were Laxatives not discontinued on diagnosis
   - Were there any unjustifiable missed doses of CDI treatment?
     - Why were there missed doses?
   - Was a sample obtained on the first day of Type 5 – 7 stools
     - Why was a sample not obtained?
   - Was the patient isolated within 12 hours from onset of diarrhoea
     - Was there a documented review regarding isolation?
     - What was the documented reason for not isolating?
     - Why was there not a documented review regarding isolation?
   - Was the most recent IPC Revalidation Hand Hygiene audit above 90%.
     - Why was Hand Hygiene below 90% compliance?
     - What actions have been taken to improve Hand Hygiene compliance?
   - Was the most recent IPC revalidation Commode audit above 90%?
     - Why was the Commode audit below 90%?
     - What actions have been taken to improve Commode audit compliance
   - Was the most recent IPC revalidation Environmental Practice score.
     - Why was Environmental Practice audit below 80%?
     - What actions have been taken to improve Environmental Practice
   - Were over 90% of boxes signed in the ward cleaning checklist
     - Why was signed ward cleaning checklist below 90%?
     - What actions have been taken to improve ward cleaning checklist
   - Was the area fogged within 7 days of the positive result?
   - Was the patient's prescribed PPI discontinued at the time of diagnosis
     - Why was the PPI not discontinued on diagnosis

- On antibiotic review by the Medical Team, in the last 3 months where there any issues with prescribing
  - Please detail the antibiotic prescription non-compliance
  - What actions have been taken to improve antibiotic prescription
- Have you reviewed the organisation and divisional *C. difficile* plan
  - Is there any new learning or any further actions that can be added
- Detail of the new learning or further action to be taken

This new process is designed to clarify what are the key elements of care that can reduce *C. difficile* for ward staff and to give them ownership for improvement of these measures. The answers are compiled into a report which is shared at IPCC. An improvement in responses is expected with 2024/2025 being the baseline.

3. Multi-Disciplinary Team (MDT) review meetings for wards with high incidence of *C. difficile.*
   As part of the PSIRF roll out, the IPC team identified 4 wards with high incidence of *C. difficile* and selected these for a more in-depth analysis of contributary factors via an MDT approach.
   This analysis confirmed some IPC and Antibiotic prescribing practice issues which needed to be addressed and also pulled out other key themes:
   - Non-compliance with National Standards of Healthcare Cleanliness
   - Aging estate with surfaces that are difficult to clean
   - Leaks of water through ceilings, some of which may be sewage
   - Lack of storage space for cleaned items which need to be kept in dirty areas
   - Poor ward lay-out (e.g., office space immediately outside side-rooms which is difficult to clean)
   - Frequent macerator blockages/breakages leading to poor faecal waste management
   - Boarding of patients leading to over-crowing and increased infectious risk.

   While a number of these issues are outside of the Trust's control at the present time, there are a number of actions that still can be taken, and the MDT review meetings have provided a clearer understanding of *C. difficile* epidemiology that will form the basis for future work.

4. Development of the *C. difficile* policy to provide clarity on testing in the context of laxative use.
   Inappropriate stool testing of non-infectious patients who have diarrhoea due to Laxatives can lead to false-positive *C. difficile* test results in some patients. This is the reason why the national guidelines advise *C. difficile* testing in patients with unexplained diarrhoea. In 2024/25 the *C. difficile* policy was reviewed and updated to give better clarity as to how to respond to diarrhoea because of new Laxatives or increased doses of Laxatives.

5. Introduction of *C. difficile* virtual ward rounds.
   In January 2025 a weekly virtual ward round was introduced which includes DIPC / ADIPC, Lead IPC Nurse/ Matron for IPC and representation from the antimicrobial stewardship team. The aim of this group is to ensure that high-risk patients for CDI are managed appropriately to prevent relapse or infection. High risk patients are those that have had *C. difficile* carriage or infection in the previous 3 months and these patients are reviewed to optimise IPC measures and testing. During 2025/2026 the IPC team will evaluate the effectiveness of the virtual ward rounds.

Significant challenges and opportunities for 2025/26

Estate and infrastructure risks (2025/2026)
LTHTR will continue to operate within the constraints of a poor and aging estate, including limited single side-room capacity. These limitations present ongoing challenges in mitigating the risk of healthcare associated infection transmission. Additionally, the Trust's current aging single-stack sewage infrastructure remains a concern due to its frequent blockages, including issues with macerators. These blockages can pose a contamination risk in patient care areas, particularly given the potential presence of *C. difficile* spores in faecal waste. Targeted risks mitigation measures will therefore remain a priority and reflected in the risk documented on the risk register. A capital bid will be prepared in 25/26 with the aim of addressing the sewage stack issues identified as a material risk. This is recognised as part of the C.difficile principal Board Assurance Framework risk.

Emergency demand and capacity pressures
ED and site-wide capacity constraints and patient boarding are expected to persist into 2025/2026. These challenges contribute to overcrowding in clinical and non-clinical areas that are not optimally equipped with appropriate facilities, such as adequate toilet access and dirty utility provisions. This situation increases the risk of healthcare associated infection transmission and remains a key operational and clinical concern. The Urgent and Emergency care plan, monitored through Finance and Performance committee is focused on addressing this risk. This is recognised as part of the UEC flow principal Board Assurance Framework risk.

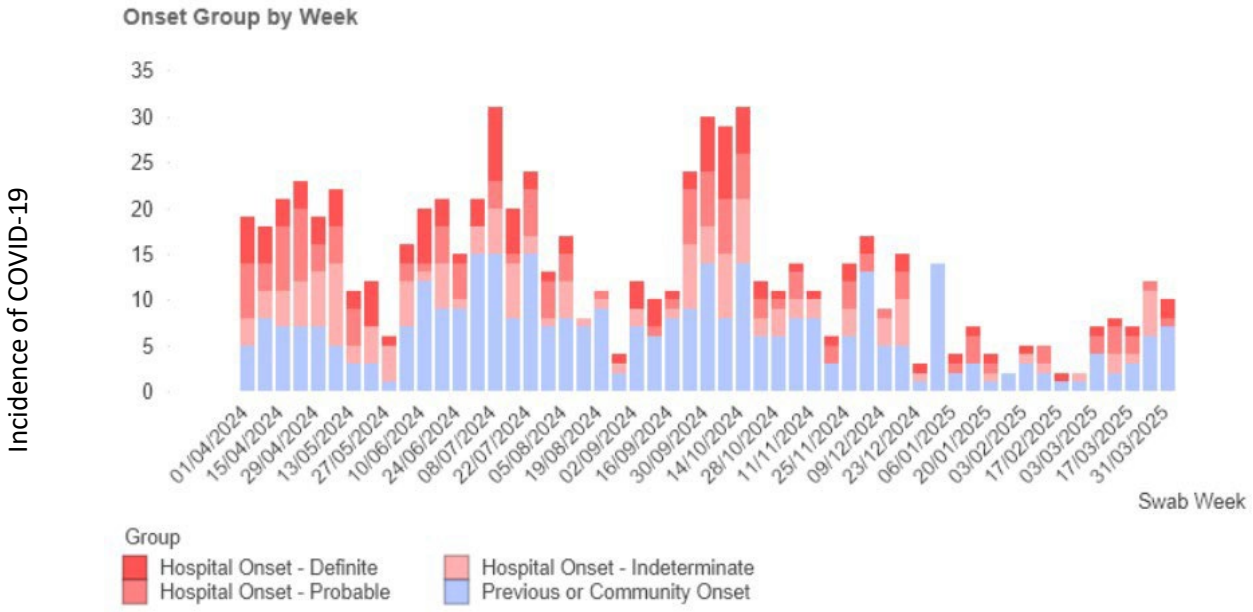
Implementation of the National Standards of Cleanliness, 2025
The adoption of the National Standards of Healthcare Cleanliness is expected to increase the frequency of surface cleaning on patient care areas. This enhanced cleaning regime is anticipated to reduce environmental contamination by spores, thereby lowering the risk of transmission of healthcare-associated infections. To ensure the effectiveness of this initiative, robust implementation is essential, alongside ongoing monitoring and evaluation on infection prevention outcomes. This is recognised as part of the C.difficile principal Board assurance framework risk.

1.3. SARS coronavirus-2 (SARS-CoV-2) - COVID-19

On 31 December 2019, World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified. The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. There were no notable changes in policy in 2024/25 as there were no changes made to the National Guidance. LTHTR has seen steady levels of COVID-19 infection throughout the 2024/2025 year.

Figure 4 shows the impact of COVID-19 on patients in LTHTR in 2024/25.

Figure 4 Hospital Onset versus Community Onset COVID-19 infections



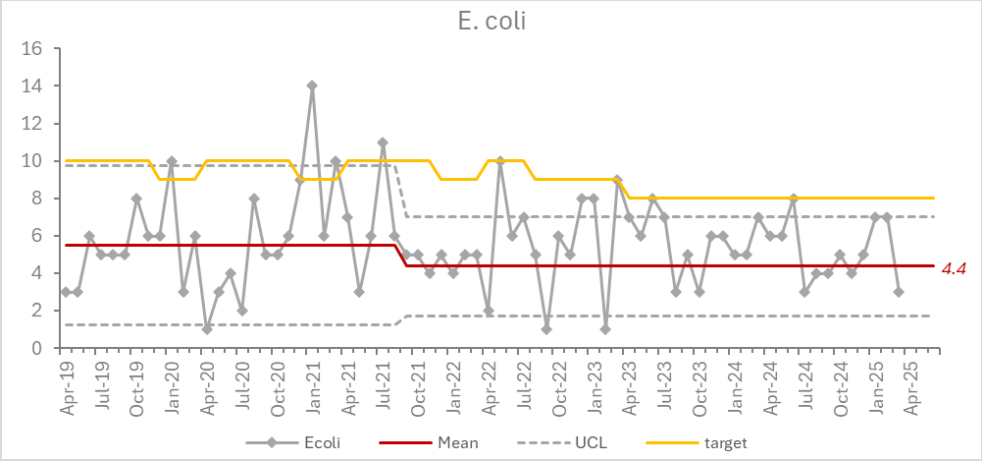
Source: LTHTR data

1.4. Gram-Negative Bacteraemia

NHSE introduced objectives for Trusts to reduce *Escherichia coli (E. coli), Klebsiella species*, and *Pseudomonas aeruginosa* in 2022/23.

The 2024/25 Objective for *E. coli* bloodstream hospital associated infections was 99. The Trust ended the year with a Total of 109 Hospital associated E. coli cases, which was 10 cases above the Objective. Tackling *E. coli* infection will require concerted action by multiple specialities and stake-holders including the Integrated care board (ICB). The ICB also plans to set up a Task and Finish groups to address Gram-Negative Bacteraemia, which includes E. coli, *Pseudomonas aeruginosa* and *Klebsiella sp*. The IPC Annual plan 2025/2026 also includes several initiatives including those related to Catheter Care, Continence and Bowel Care.

Figure 5 Hospital Associated *Escherichia coli* positive rates per month.



The 2024/25 Objective for *Pseudomonas aeruginosa* Bacteraemia Hospital Associated Infections was 16. LTHTR ended the year with a Total of 12 Hospital Associated *Pseudomonas aeruginosa* Bacteraemia cases for 2024/2025, this is 4 cases under the objective.

The 2024/25 objective for *Klebsiella* species bloodstream Hospital Associated Infections was 29. The Trust ended the year with a Total of 31 Hospital Associated Klebsiella species cases for the year 2024/2025, this is 2 cases above the objective.

1.5. OTHER OUTBREAK INVESTIGATIONS IN 2024/2025

1.5.1.1. Norovirus outbreaks

The year 2024/2025 saw 29 Confirmed Norovirus Outbreaks. 11 confirmed Outbreaks from April to June 2024, 8 Outbreaks from October to December 2024 and 12 Outbreaks from January 2025 to March 2025. This matched the current National picture with increased spread of new variant of Norovirus (GII.17) to a more susceptible population that had not been exposed to such viruses during the COVID-19 Pandemic.

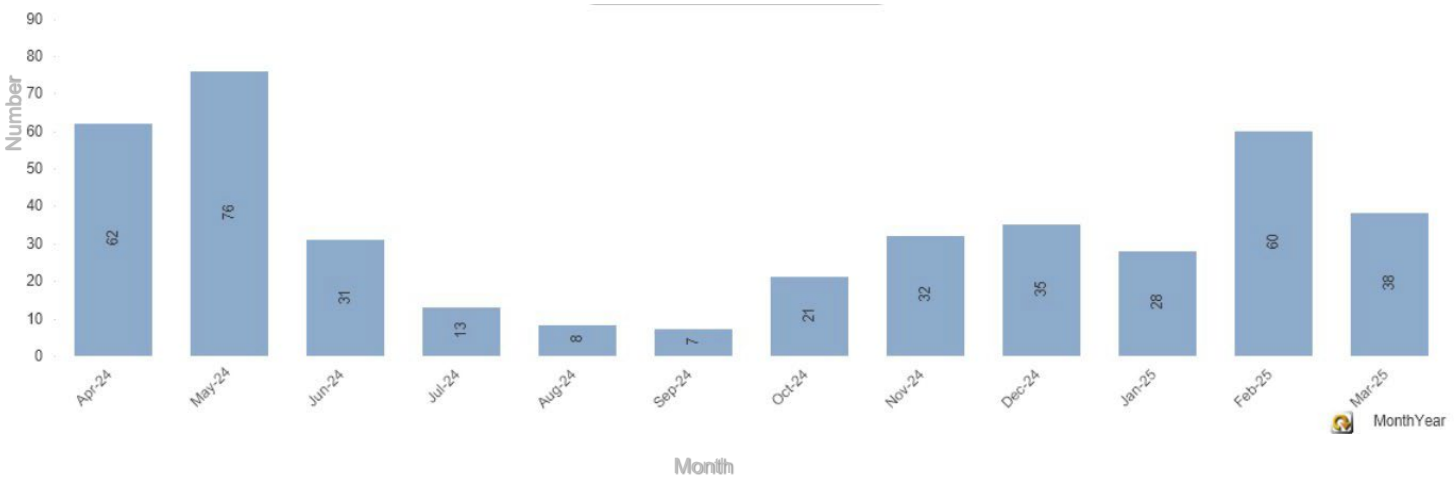
Between April and June 2024, and again from October 2024 through March 2025, there was an observed increase in the number of patients presenting to the Emergency Department and Assessment Units with symptoms of diarrhoea and vomiting, originating from community settings. This trend placed significant pressure on the Trust's capacity to appropriately isolate symptomatic individuals, thereby increasing the risk of healthcare-associated transmission. Additionally, there was evidence indicating that some outbreaks were initiated by symptomatic staff and visitors, further contributing to the transmission of viral gastroenteritis within inpatient areas.

Norovirus outbreaks have a disruptive impact on patient flow during times of high incidence due to closure of bays and sometimes wards across both sites. The resulting trapped beds reduce the hospitals effective bed capacity and prolong E.D. waits. Whilst the norovirus outbreaks that we experienced were significant, the Trust benefits from the availability of a rapid intestinal screening test (provided by the point of care team) which allows for early identification of patients with Norovirus in E.D. and in ward areas. Negative tests also support the IPC team in their decisions to keep unaffected bays on outbreak wards open, minimising disruption.

As a Trust there has been increased focus on Enhanced cleaning to reduce the bioburden of infection within the Environment, IPC precautions to mitigate the risk of spread, and the completion of Fogging following the

infectious period to mitigate the risk of the transmission of the virus to new patients. This prevents further waves of outbreaks. Communications were circulated reiterating protocols to staff to ensure that they refrain from work until 48 hours clear of symptoms. Communications were also circulated to the public, so visitors do not attend to visit patients at the Hospital when they unwell with symptoms.

Figure 6 Number of confirmed positive Norovirus Patients April 2024 – March 2025 (excluding patients identified in outbreaks that are likely Norovirus positive but not tested)



Source: LTHTR data

1.5.1.2. Influenza

Influenza is an acute viral infection of the respiratory tract that spreads easily from person to person. Influenza viruses cause seasonal epidemics in winter in temperate climates, as in UK. There are 2 groups of Influenza virus, Influenza A and Influenza B which cause infection in humans. The epidemiology of Influenza is unpredictable as Influenza viruses continually change and evolve, which is why a new vaccine is developed for each season.

Transmission of Influenza occurs mainly by droplets, which can travel up to 2m through the air and by direct and indirect contact. Aerosol-generating procedures such as Bronchoscopy and non-invasive ventilation can produce small particles which can travel further than droplets and remain in the air for longer. Prevention of Influenza is by vaccination and basic hygiene including hand hygiene and cough / sneeze etiquette.

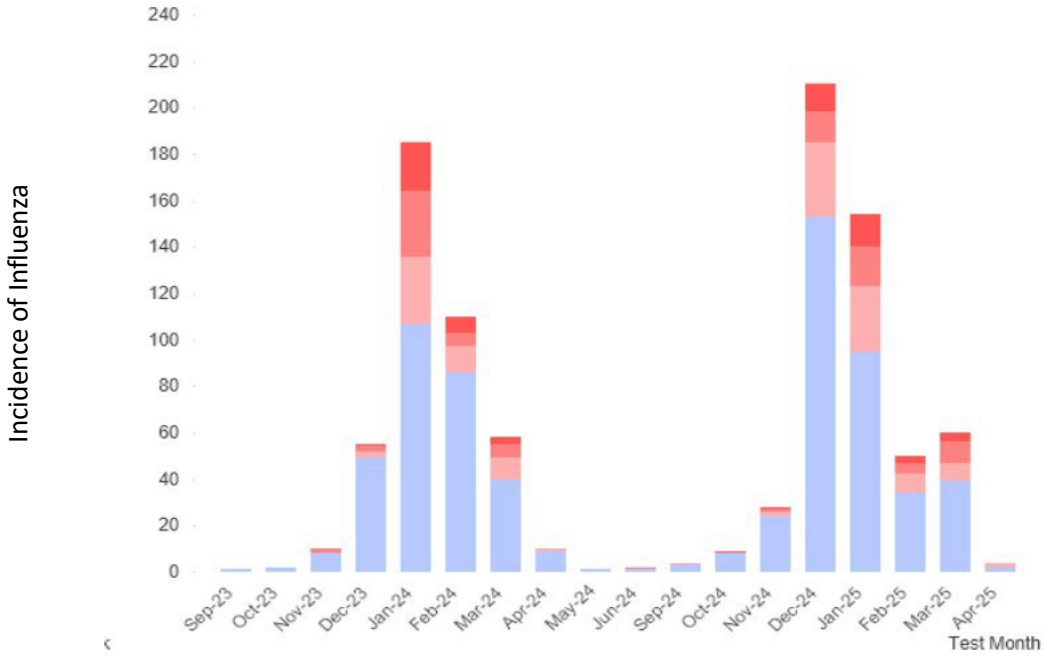
Isolation in single rooms and use of appropriate personal protective equipment (PPE) for suspected and confirmed Influenza cases is also key to preventing Influenza transmission in healthcare. When the number of single rooms exceed the single room capacity, cohort of Influenza cases can be implemented by subtype. In temperate climates, the incidence of Influenza is seasonal and peaks in winter usually between January and March.

The Emergency Department (ED) is supported by a 24/7 point of care testing service, which provides influenza testing as well as a range of other tests. Patients presenting to ED with respiratory symptoms compatible with Influenza / COVID-19 are tested at triage and then asked to wear a mask when they go into the waiting area to minimise the risk of transmission. The point of care testing service also provides testing for inpatient areas where infection is suspected and to manage outbreaks.

Influenza season 2024/2025

The Influenza season in LTHTR for 2024/25 started in November 2024 in line with the National pattern and peaked in late December 2024 / early January 2025. As seen is other Trusts, there was a higher incidence of Influenza in 2024/2025 as compared to 2023/2024, and there was also a high proportion of cases that tested positive 3 or more days after admission (likely Nosocomial cases). Staff reported that, even with a positive test, it was not always possible to isolate patients with influenza in ED. Due to pressures in the department, patients needed to be nursed in corridors with masks waiting to be seen, or in other multiple-occupancy areas increasing the risk of transmission of infection.

Figure 7 Influenza positive patients by onset. The community cases are represented in BLUE and the potential Nosocomial cases are represented in the shades of RED



Source: LTHTR data

1.5.1.3. Measles National Outbreak

Measles was formally removed from the Infection Prevention and control risk register in 2024/2025 due to a significant reduction in community transmission. During the previous reporting period, a Trust-wide policy for the management of patients with Measles was developed and disseminated to all staff. In parallel, the Occupational Health Department conducted a review of measles immunity status among staff working in identified high-risk roles and departments to ensure appropriate protection and preparedness.

Throughout 2024/25, the local risk of community outbreaks remained low. A total of three confirmed measles cases were reported in the community; however, none of these individuals required hospital attendance, and no associated hospital exposure occurred.

1.5.1.4. Carbapenemase-producing Enterobacterales (CPE)

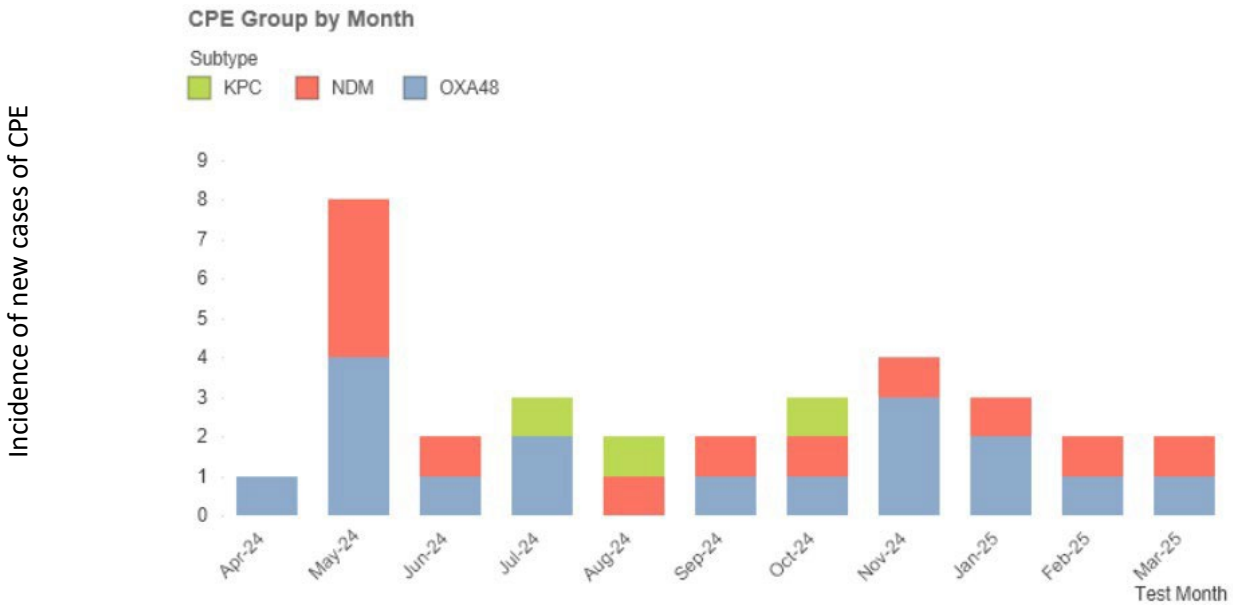
Enterobacterales producing acquired Carbapenemases are referred to as CPE. The most prevalent enzymes in the UK are KPC, OXA-48-like, NDM, VIM, and IMP. Increasing gut colonisation with these resistant bacteria will inevitably lead to an increase in difficult-to-treat infections. These strains of bacteria

are highly resistant, only treatable with novel, expensive antimicrobials, and often linked with higher mortality rates.

The IPC Team is supported by data on the internal Trust application, QlikView that shows a CPE dashboard which provides an overview of active CPE colonised patients in the hospital and allows them to assess trends in the incidence. New positive results are also transmitted to the IPC Microbiology alert list for action in real time. The IPC Team create an infection alert on Harris Flex to ensure historic patients are isolated on admission and screened as per policy.

In 2024/2025 the IPC Team identified 32 new CPE positive cases (similar to the previous year: 31 cases); 17 OXA-48 positive patients;12 NDM positive patients, and 3 KPC positive patients. There were no outbreaks, and the patients had risk factors for acquisition of the organism abroad or in other hospitals.

Figure 8 Carbapenemase-producing Enterobacterales Group by month April 2024 – March 2025



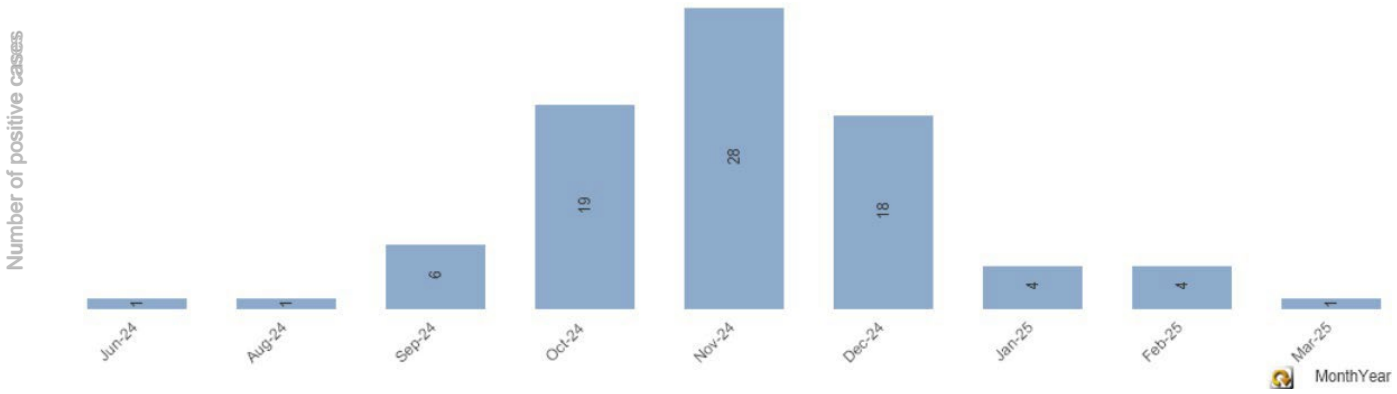
Source: LTHTR data

1.5.1.5. Respiratory Syncytial virus (RSV)

Respiratory syncytial virus (RSV) is an enveloped RNA virus, in the same family as the Human Parainfluenza Viruses and Mumps and Measles viruses. RSV is one of the common viruses that cause coughs and colds in winter, however, infants under 1 year are at particular risk of severe infection requiring admission to hospital (e.g., croup).

In 2024/2025, RSV peaked in November and the RSV season was less severe than in 2023/2024, which was a particularly severe winter. The peak month in 2024/2025 season saw 28 RSV positive children presenting to hospital, as compared to 59 cases in the peak month of the 2023/2024 season.

Figure 9 Volume of Respiratory syncytial virus (RSV) positive cases April 2024 – March 2025



Source: LTHTR data

1.6. KEY INTERVENTIONS TO PREVENT NOSOCOMIAL INFECTION

1.6.1.1. Staff training compliance

IPC Mandatory training, including ANTT compliance, is reviewed at the Divisional IPC / Always Safety-First monthly meetings with oversight at IPC Committee within the IPC Team report broken down Divisionally. Areas that are not over 90% compliant are flagged and escalated negatively to the Safety and Quality Board via Chair's report.

Figure 10 Infection Prevention and Control Level 1 and Level 2 E-learning compliance 2024/2025

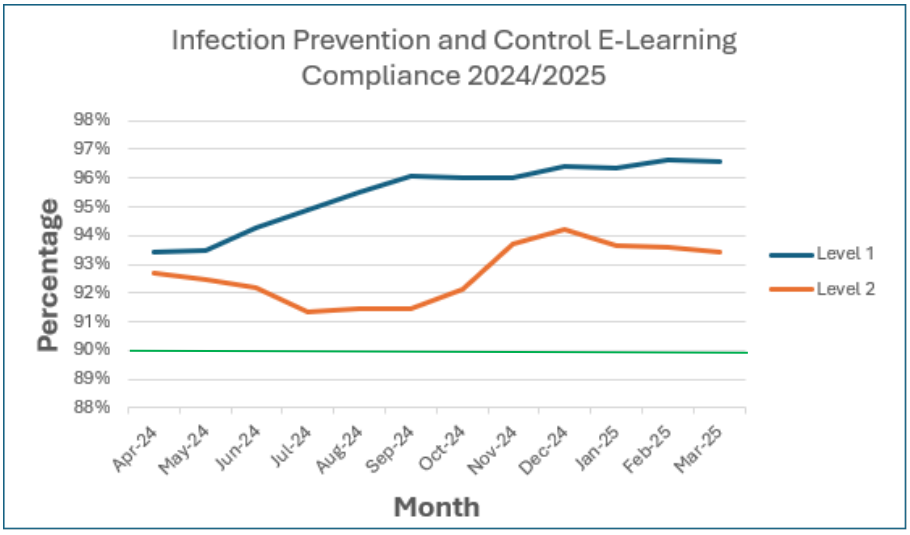


Figure 10 demonstrates that the Trust is achieving its target of over 90% compliance with IPC Mandatory training and this is consistent throughout the year. All Divisions are achieving this target (data not shown).

Matron and ward manager training

In October 2024, the first Community of Practice (add agenda as an appendix) was held and titled Securing safety in frontline defence: Best practice in IPC standards. A community of practice is a group of professionals who share common interests, expertise and goals and who come together to improve their skills, share experiences, compare notes, learn from each other and to collaborate on best practice. This

event saw 98 Matrons, ward managers and clinical leaders come together to discuss and agree the way forward to collectively manage IPC standards. The forum also allowed the specialist knowledge of the IPC team to teach Matrons and ward managers the most up to date information in relation to IPC. The agenda is attached as appendix 5.

1.6.1.2. Assurance Platform

The IPC Committee identified the need for specific process and outcome data to be available at departmental level. The Business Intelligence Team developed an IPC Dashboard which includes data fields such as IPC Audits, STAR Audits, Average days to isolation, CDI numbers, IPC Datix incidents, IPC Complaints, Training compliances, and non-bed transfers. The data fields allow for triangulation of IPC compliance with levels of Hospital Acquired Infections. The availability of this data will support early escalation, action and prediction of risk and is considered by IPC committee to be an essential action for further reduction in hospital acquired infections.

The accreditation process STAR audits are also reflected within the IPC Teams report. The Matron for IPC and STAR meet regularly to review the IPC elements of STAR with the compliance of Infection Prevention and Control being reviewed and audited frequently as part of the mandatory checks.

Figure 11 STAR accreditation compliance for Infection Prevention and Control (Environment clean, tidy and clutter free)

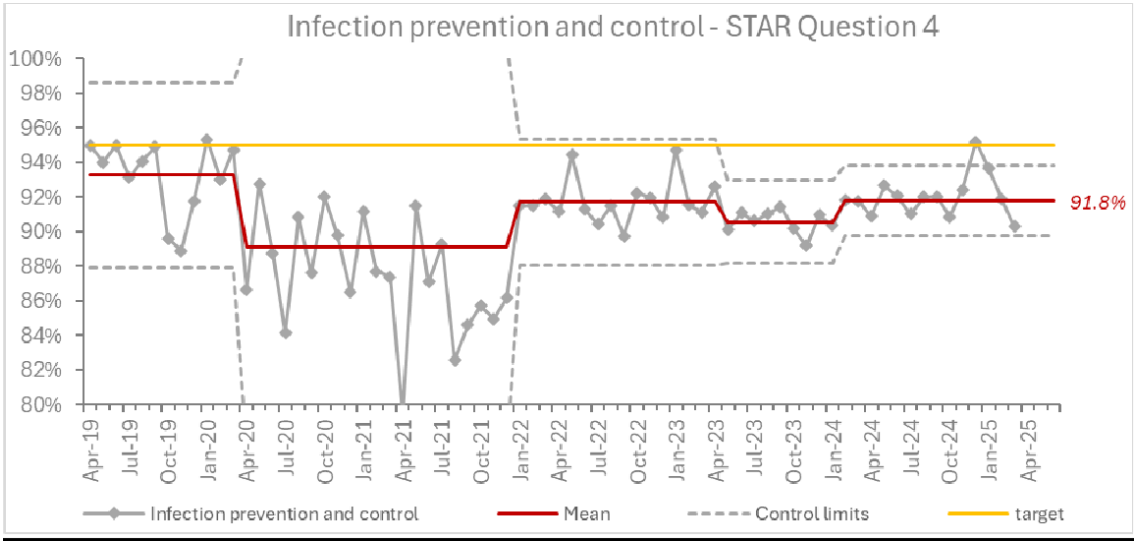
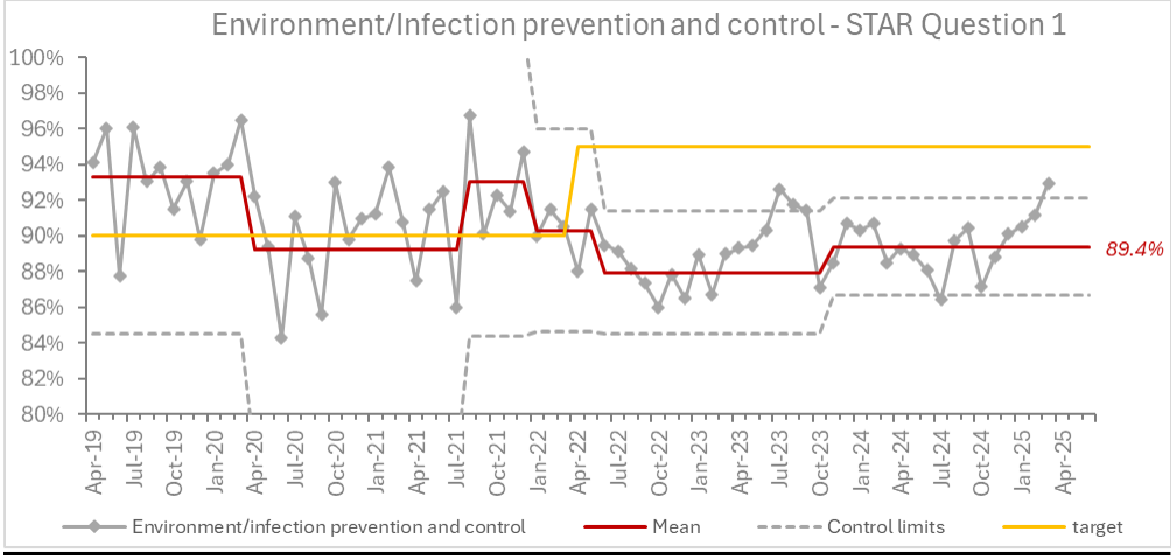


Figure 12 STAR accreditation compliance for Environment/Infection Prevention and Control (Department appears well-organised, clean and clutter free)



1.6.1.3. Antimicrobial Stewardship

The Trust Antimicrobial Management Group (AMG) meets every two months to review antimicrobial stewardship and includes representation from Microbiology, Pharmacy in both LTHTR and the community, Sepsis Team and the Infection Prevention and Control Team.

In 2024/2025 the Antimicrobial Stewardship (AMS) Team have continued with a broad range of Antimicrobial Stewardship activities including guideline updates, antimicrobial ward rounds, audit, and teaching. For World Antimicrobial Resistance Awareness Week, a video was created involving children sharing key messages relating to AMS to support good practice. This has been shared Nationally as well as locally and has been entered for consideration to the Antibiotic Guardian Shared Learning Awards.

Quarterly antibiotic prescription points prevalence audits are undertaken to promote good Antimicrobial Stewardship and safety in the management of antibiotics. The Trust has remained >90% compliant with documented indication on the drug chart and documented review within 72hrs for the full year. Compliance with Antimicrobial choice in line with guidelines or recommended by Microbiology was also >90% for the most quarters whilst in Q3 it was 85%. Several additional antimicrobial audits were proudly presented at the international Federation of Infection Societies (FIS) conference November 2024.

A key focus over the past has been prompt IV to oral antimicrobial switch. This has many benefits including potential reduced length of stay, improved patient outcomes and significant cost savings. Reduction in proportion of IV antibiotic use was included in the Trusts Single Improvement Plan and the AMS team is on track for achieving the target set. Continued focus on this is required in the next financial year to maximise the broad benefits.

LTHTR also has the best result within the local ICB for performance against the NHS standard contract target of 10% cumulative reduction in ‘Watch’ and ‘Reserve’ category antibiotics (as defined by the World Health Organisation) from 2017 baseline. Further work is needed to meet the target.

1.6.1.4. Water Safety

The Trust Water Safety Group (WSG) is continuing to meet virtually but due to operational Estates pressures and vacancy rate and vacancy freeze within the operational Estates management team the WSG meeting schedule has been delayed. However, the WSG reports to the Trust Health and Safety Governance Committee along with providing information to the Infection Prevention and Control Committee in relation to any potential waterborne infection risks. In 2025 The Trust Water Safety Group will be supported with the implementation of an operational Estates Water Safety Meeting which will focus primarily on operational and capital technical issues.

The Trust Water Safety Plan remains in place and capital developments are managed in line with this. Hydrop, who provide the Trust's Authorising Engineer for Water have updated the Trust Water Safety Plan in line with new/revised guidance. The Authorising Engineer conducted the water safety audit in line with Health Technical Memoranda (HTM) 04. Overall, the audit outcome is positive considering the ageing estate, and an action plan has been implemented to progress the identified improvement work.

The Trust authorising engineer Hydrop has completed a full legionella risk assessment review of Royal Preston Hospital and Chorley District Hospital. The review has created recommendations and prioritised remedial actions. The operational Estates team are currently reviewing the action plan and applying for necessary funding.

Water testing for Pseudomonas aeruginosa (P. aeruginosa) continues in Augmented Care Areas in line with Health technical memoranda (HTM) 04-01 with samples collected every 6 months. If out of range results occur, these are dealt with in line with the Water Safety Plan and HTM guidance. Additional water samples are taken following remedial works in response to this.

Legionella sampling continues with the revised programme agreed in 2022. The targeted augmented care areas have been reviewed with the DIPC and infection prevention control Matron to ensure the testing regimen is aligned with the clinical services being provided. Out of range results are dealt with in line with the Water Safety Plan and HTM guidance. Additional water samples are taken following remedial works in response to this.

To strengthen the control of Legionella and to ensure compliance with current guidance, the trust has engaged a specialist contractor to undertake maintenance, disinfection, and operation of all thermostatic mixing valves within the Trust.

1.6.1.5. Ventilation

The Estates services department continue to implement the relevant guidance within HTM 03 to control the risk of airborne particulate transmission. The operational Estates team have found the past year challenging due to vacancies within the team and the trust financial position. The operational Estates team continue to work closely with the Estates capital team to identify and prioritise infrastructure backlog capital programme for 25/26. The operational Estates team continue to engage and independent authorising engineers to ensure new mechanical ventilation systems comply with new HTM guidance.

The guidance provided within health care standards HTM 03-01 & associated HBN`s have changed over the time. Therefore, there is a high variety of standards and design specifications regarding mechanical ventilation in use across LTHTR. A proportion of mechanical ventilation systems throughout LTHTR are in general ageing condition and have reached recommended life cycle. Some of the inpatient areas in Royal Preston Hospital are particularly poorly ventilated in general.

Estates services continue to engage Medical air Technology (specialist contractor) to undertake the re-verifications of critical ventilation systems throughout LTHTR in line with Health Technical Memoranda (HTM) 03-01 guidance which is implemented in line with the trust ventilation safety policy and the ventilation safety group.

The operational Estates team have revised and implemented a Health Technical Memoranda (HTM) compliant maintenance schedule for all mechanical ventilation plant throughout LTHTR. Authorised person ventilation training has continued for the new engineering managers who have recently joined the trust. Competent person training for mechanical trade operatives is continuing by the Trust Authorising Engineer for new starters with the team.

1.6.1.6. Decontamination

The Sterile Services Department

This annual decontamination report provides a comprehensive overview of the decontamination activities conducted within the Sterile Services department in compliance with HTM01-01 standards throughout the year 2024. It covers several aspects including maintenance, incident reporting, staff training, audit compliance, recruitment, and continuous improvement

Compliance with HTM01-01 Standards

Throughout the reporting period, the Sterile Services department demonstrated diligence in maintaining compliance with the HTM01-01 standards and ISO 13485:2016 Quality Management System. The highest standards of decontamination procedures were upheld by conducting frequent internal audits and inspections to ensure compliance with the guidelines. By consistently adhering to the HTM01-01 standards, the department contributes to the overall quality assurance of the Trust and patient safety. These standards ensure that proper measures are in place to prevent the spread of infections and maintain a clean environment.

Incident Reporting:

One field safety notice (FSN) received in 2024. FSN Issued white residues on Sterilization of BBRAUN Containers. The containers are made of anodized aluminium. If anodized aluminium is subject to cleaning/disinfection solutions outside the defined pH range and inappropriate re- processing parameters (water quality, temperature and duration of the drying phase), white residues (oxygen-containing aluminium compounds) may form on the Device's inner and/or outer surface

Action: Staff were briefed about updated IFU and if they come across any BBRAUN containers with white residues will report to HSDU office. There is no risks, adverse effects and interactions can currently be found in HSDU Unit

Staff Training

All staff members received comprehensive and up-to-date training on decontamination procedures. During the ISO external audit in November 2024, all training records were reviewed, and the QMS audit report confirmed there were no gaps in the training process. Continuous training and development were implemented to ensure that our staff remained competent in their roles and knowledgeable about the latest updates and best practices in decontamination process. Instrument washers and autoclave manufacturer training were provided and included in the staff training matrix.

ISO 13485 Compliance

The Sterile Services department successfully passed the ISO 13485 audit in 2024 with only two minor non-conformities. This achievement demonstrates the Trust's constant commitment to maintaining the highest levels of quality in decontamination procedures and maintaining quality management.

The Sterile Services department started several key projects to improve decontamination services and infrastructure within the Trust

- **Capital Replacement Programme:**
  Four new washers and three autoclaves were installed to increase capacity, with Belimed Smart Hub monitoring system for improved tracking and oversight of machines and autoclave performance.

- **Quality Management System**
  A new Quality Management System (QMS) was introduced in 2024 to streamline processes and reduce the reliance on paper documentation. Transitioned from paper-based records to electronic version. The QMS will be regularly updated to reflect any changes in decontamination processes, ensuring ongoing compliance with HTM01-01 standards and ISO 13485:2016. The new system is designed to help easier preparation for internal and external audits, ensuring that all records are up to date and readily available.

Decontamination in other areas of the Trust

Decontamination - The Trust decontamination lead has limited capacity to fulfil all the requirements of the role. Reports are provided on a quarterly basis to IPCC for assurance. This represents a risk for the Trust and discussions are underway to mitigate gaps and this will be added to the risk register.

Currently, the manager for sterile services fulfils this role and supports the wider organisation by providing expert advice where required and performs audits for Longton Day case, RPH main theatres and the main endoscopy units (CDH and RPH).

In 2024/25, the DIPC and the manager for the Sterile Services department performed an inspection of areas where unaccredited flexible endoscopy is performed. A report has been prepared that will be submitted to IPCC in April 2025.

1.6.1.7. Environmental Cleaning/Disinfection and Waste Management

Domestic Services

The Domestic Services Team utilise a variety of modern cleaning methods to ensure high standards of cleanliness, across the Trust. Below are the operating practices and methods used to clean and disinfect the environment, offering our full assurance to standards:

- Scheduled Cleaning
- Enhanced Cleaning
- Terminal (Vacation) Cleaning
- Deep Cleaning
- Disinfection HPV
- UV-C Light Disinfection: Utilisation of ultraviolet light to disinfect surfaces and air, particularly in high-risk areas.

In 2024/2025, the Domestic services Team were successful in a business case to implement UV-C Technology, and this has been implemented on the Preston site.

UV-C devices are widely used for room surface decontamination in healthcare settings. The state-of-the-art cleaning equipment uses high intensity UV-C light to automatically decontaminate rooms and surfaces quickly and effectively as a supplement to manual cleaning especially where there is a potential risk of transmission of a harmful organism. It is also well-suited for high-throughput areas where patients are being regularly admitted and discharged, allowing staff to maintain turnaround speeds and prevent backlogs without compromising on patient safety. The department is working to introduce regular UV cleaning of the sluice rooms, supported by our Rapid Response team.

In 2024/2025, the Domestic Services Team also contributed to writing a business case for implementation of National Standards of Healthcare Cleanliness (2021) which has been approved. Since then, the national Standards of Cleanliness have been revised and reissued (2025) and the analysis of these identifies that the investment agreed against the 2021 standards will also ensure that the Trust is compliant with the 2025 standards. These will be implemented as a phased approach during 2025/2026.These methods are part of a comprehensive approach to maintain a safe and hygienic environment for patients, staff, and visitors.

Figure 13 Environmental Cleaning / Disinfection
Global Red Clean (Fogging) inc. UV comparison April 2024 – March 2025

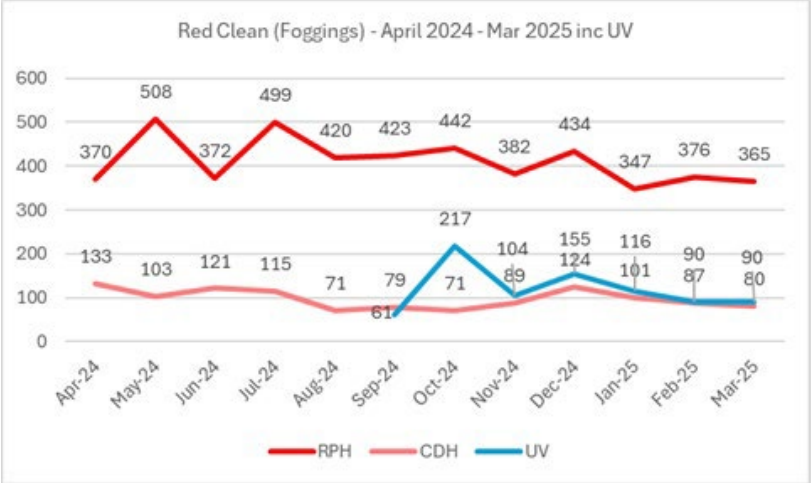
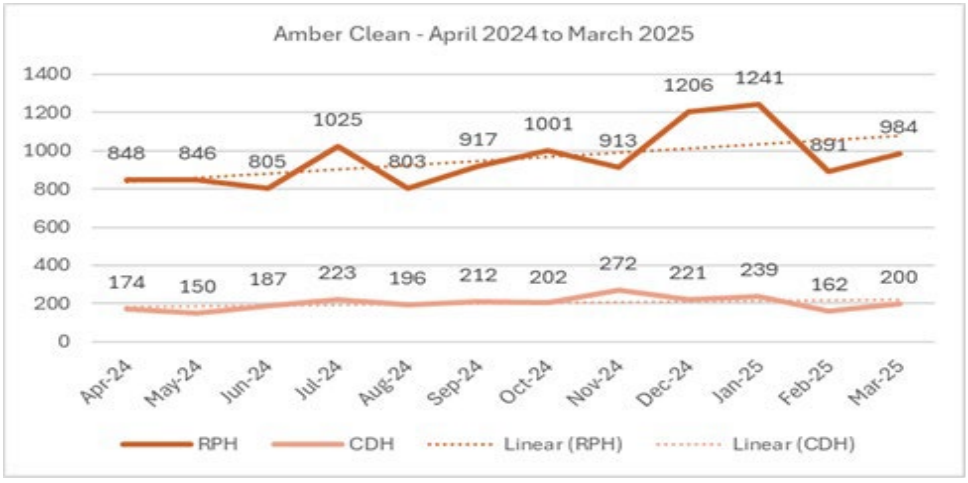


Figure 14 Amber Clean April 2024 - March 2025



Waste management

The Trust is still in the process of implementing the colour coding for clinical waste across all sites. This not only follows good practice but also ensures it is not over treating waste streams and is using the most cost-effective disposal routes. A new clinical waste contract has been negotiated working with other Trusts in the local Integrated Care Board (ICB), providing Lancashire Teaching Hospitals with some opportunities for cost savings.

The Trust continues to separately recycle certain waste streams such as cardboard, plastic bottles, wood, metal waste electrical and electronic equipment, batteries, mattresses, fluorescent tubes, confidential paper waste (following shredding), cooking and engine oils. New Simpler Recycling legislation will be introduced from April 2025 which will require the Trust to introduce a "mixed recycling" waste stream and work is currently on-going for this project.

The Trust's reuse portal for furniture, equipment and stationery is still growing in membership and has been particularly important in saving the Trust money over 2024-25. In the last 11 months we have saved £52, 500, avoided 5.8 tonnes of waste and nearly 28 tonnes of carbon by repurposing items across our sites. Where feasible our wards and departments are reupholstering furniture using a local service, which again reduces waste and cost and works towards our sustainability targets.

The Trust is working with our partners in other Lancashire based Trusts to progress a mobility aids reuse project, mainly for crutches, walking sticks and frames. This does require additional on-site space to expand properly, but we are still moving forward with this initiative in the meantime.

Work is progressing on the Trust's new and updated Green Plan, which includes elements for waste management. This is in line with promotion of our Sustainability Hub and regular sustainability newsletter communicating ideas, hints and tips to our staff for use in both the work and home environments. We are encouraging more of our staff to become involved in sustainability projects and consider becoming Sustainability Champions too.

Additional work is required to review our suppliers/providers regarding their sustainability policies and procedures, as required in our Green Plan commitments and sustainability. This will include less reliance on single use products, in particular plastics. This requires local responsibility from all wards and departments to make more informed purchasing decisions aimed at reducing waste completely, or where this is not possible, ensuring waste can be reused, recycled or recovered more easily.

A key element of making changes to the Trust's waste management systems will involve raising awareness and staff training, which will be introduced alongside the colour coding changes. This will hopefully encourage our staff to think differently about waste and prioritise minimisation, reuse, recycling and recovery over disposal, whilst still ensuring compliance and health and safety.

1.7 Research

Primel study

In October/November 2024, the IPC team successfully led the implementation of a research study investigating a novel hand hygiene product – Primel® Active Hand Coating (PAHC).
Unlike conventional alcohol-based hand sanitiser, PAHC not only provides immediate antimicrobial activity but also offers a sustained residual effect for up to 48 hours, even with routine hand contact, until it is washed

off. Additionally, PAHC-coated hands have been shown to actively reduce contamination on surfaces they touch, demonstrating a unique “Protect on Touch” effect.

The purpose of our evaluation was to demonstrate PAHC residual activity, hand to surface contamination and “Protect on Touch” effect in a hospital inpatient environment. The results were very positive, and the product demonstrated residual activity and a reduction in surface contamination. The IPC team is developing a new protocol for expanded use of the product in specific settings of the hospital and plan to apply for research funding in the coming year

2. Financial implications

Effective management of Infection Prevention and Control in acute hospitals is not only critical for patient safety and clinical outcomes but also delivers substantial financial benefits to healthcare systems. By reducing the incidence of healthcare-associated infections (HCAIs), robust IPC programs help avoid the significant costs associated with extended hospital stays, additional treatments, readmissions, and antimicrobial resistance.

Each prevented infection translates to considerable cost savings depending on the type and severity of the infection. Furthermore, strong IPC measures reduce staff sick leave, enhance bed availability, and improve patient flow, which contributes to operational efficiency and resource optimisation.

IPC is a high-impact, cost-effective strategy. It protects patients and staff, supports better clinical outcomes, and delivers measurable financial returns across the entire health system.

In the reporting period the main schemes to reduce healthcare associated infection rates are:

- Co-production of an investment case for extra domestic resource to become compliant with 2021 National Standards of Healthcare Cleanliness – 750K
- Maintenance of rapid testing approach to ensure isolation capacity continues to be used efficiently.
- Water testing
- Ongoing drainage repairs and need for investment
- Estate remedial works

These will be managed through the Trusts governance processes.

3. Legal implications

Failure to comply with Infection Prevention and Control (IPC) standards in healthcare settings can lead to legal consequences for both institutions and individual healthcare professionals. These may include:

- **Regulatory Sanctions**
  Healthcare facilities are subject to oversight by national and regional health authorities. Non-compliance can result in enforcement actions such as fines, suspension of services, revocation of licenses, or mandatory corrective action plans.

- **Litigation and Liability**
  If a patient acquires a healthcare-associated infection (HAI) due to poor IPC practices, the institution may face civil lawsuits for negligence. Courts may find the hospital liable if it is shown that standard precautions were not followed and harm resulted.

4. Risks

ID	Title	Current Score
1157	Increased *C. difficile* Infection	20
1302	Insufficient side rooms to meet Infection prevention & control requirements & demand	12
2081	There is a significant risk that if service vacancies are not filled, Portering, Domestics services, Catering and Linen will move into full BCP. Impact across patient safety, inability to support C Diff infection control procedures, risk to patient mealtimes, significant delays to patient transfers leading to negative impact on patient journey and associated discharge. Significant reputational risk	16
1847	The revised NSoC 2021 are not fully embedded across the Trust. The domestic service provision has been realigned to move resource to prioritised areas (as identified by IPC and the Executive Oversight Group C.Diff) this has resulted in 15 wards adhering to the standards with the remainder of the Trust, Gynae, Main, Vangard and Plastics theatres and ED A cost pressure has been submitted for the 2024/25 financial year of £1.2m which is the gap from the current FM budget. Cost pressures have been submitted in the previous two financial years to identify this gap which have been unfunded. The domestic services team have exhausted their ability to implement in any other area without additional funding.	16
1213	Operational Estates managers and trade staffing gaps in cover	12
1001	Risk to Safe Management of water Supplies and Contamination to Water Systems	12

5. Impact on stakeholders

Infection control plays a critical role in patient safety and experience outcomes. Infection leads to increase in treatments and length of stay and colleague sickness. Therefore, the prevention of infection plays an important role in the available bed and colleague capacity within the services.

6. Recommendations

It is recommended that:

i. The Council of Governors note the contents of the Annual report noting the progress against the 2024/25 Annual Plan in Appendix 1 and the approved IPC Annual Plan for 2025/2026 (Appendix 2).

Appendix 1 – IPC 2024/25 Annual plan
Appendix 2 – IPC 2025/26 Annual plan
Appendix 3 – *C. difficile* Improvement plan
Appendix 4 – Infection, Prevention and Control Structure
Appendix 5 - Community of Practice study day

Appendix 1

Infection Prevention and Control (IPC) Annual Programme 2024/2025

The annual programme for 2024/2025 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2023/2024. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of any new learning and shared good practice, is a key strategy to support the Annual Programme. The PSIRF process introduced in 2024/2025 continues to be strengthened. This process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) IPC Team Infrastructure 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Review of incidents & risks 6) Environment 7) Antimicrobials 8) IPC preparedness & Resillience 9) Policies & Procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning and communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Inter-relations / Wider Community / Strategic working	1.1.1	Standardise working across the ICS	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively with the ICS providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3	Y		Monthly meetings are held with neighbouring Trusts within the ICB with IPC leads. These meetings are scheduled continously to support standardisation of IPC strategies and outbreak management.
	1.1.2	Provide consultancy for external charities to support in IPC practice	1,2,3,4,5,6,7,9	Matron IPC	Provide Derian House Children's Hospice with IPC support and Annual Audit	Matron IPC / IPC Team	Q2	Y		**Appendix 1.1.2 Derian House Audit Email**
	1.1.3	Share learning from incidents across the ICB	1,2,7,9	Matron IPC / IPC Lead Nurse	IPC Lead Nurse and Matron to visit an exemplar NHS Trust to review IPC practices and ways of working for shared learning on best practice.	Matron IPC / IPC Lead Nurse	Q3	Y		Work has been shared and meetings have been held virtually with the IPC Leads from Mersey and West Lancashire Teaching Hospitals and Manchester University NHS Foundation Trust with a plan to visit eachother after winter pressures. Our C. difficile policy and improvement plan has been shared with these Trusts.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q4	Y		**Appendix 2.1.1 RE IPC E-learning package**
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	Strengthen learning for the bed management team based on best practice guidelines and real life clinical cases. Continue to provide education on the correct use of isolation rooms and audit current usage to support capacity	IPC Team	Q2, Q4	Y		Audits are completed daily by Bed Management with support from the IPC team regarding de-isolation. The IPC team attend daily Bed Meetings and work with capacity managers to improve patient flow. **Appendix 2.1.2 Isolation Procedure V9 - ref checked**
	2.1.3	Continue the Infection Prevention and Control face to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Continue with education sessions for IPC across the Trust	IPC Team	Q1,2,3,4	Y		Ad hoc support and guidance on IPC principles are given when non-compliance is identified during the IPC revalidation audit results. **Apprendix 2.1.3 IPC Link Nurse Days April 2024. Appendix 2.1.3 IPC Link Nurse Days November 2024. Appendix 2.1.3 IPC link nurse day November.**
	2.1.4	Reduce reoccurring themes and trends identified in MDT reviews and/or outbreaks.	1,2,3,4,5,6, 7	Matron IPC	Provide bespoke IPC training for departments following MDT reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3	Y		Bespoke training on Hand Hygiene, Commode cleanliness, and Bare Below the Elbow compliance has been completed on Wards following the PSIRF CDI MDT reviews.
	2.1.5	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead / DND's	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead / DND's	Q2	Y		Targeted competency compliance is underway with the compliance for Foundation Doctors improving moth on month. **Appendix 2.1.5 IPCC Minutes - January 2025**
	2.1.6	Improve patient education on the importance of IPC principles (Hand Hygiene).	1,2,4,9	IPC Team / Patient Saftey Partners	Work with the Patient Safety Partners to develop a patient information package to empower patients who access Trust services	IPC Team / Patient Saftey Partners	Q2	Y		A leaflet and safety video including IPC principles have been created and approved with plans to pilot on Ward 17. Placemat testing will be put in place following feedback from the leaflets. **Appendix 2.1.6 IPCC Minutes - November 2024**

		Ongoing Task			Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via Trust comms, saftey bulletins, and social media	4,6	Matron IPC	Communicate Trust-wide regarding immediate safety and learning concerns, and celebrate good practice.	IPC Team	Q 1,2,3,4	Y		**Appendix 3.1.1 Social Media Content. Appendix 3.1.2 Bin the wipe campaign communication. Appendix 3.1.3 ASF Learning bulletin 3.1.4 Bin the wipes campaign intranet link. Appendix 3.1.5 Infection Prevention and Control Week 2024 intranet link. Appendix 3.1.6 C. difficile Awareness Month 2024 Intranet Link**
	3.2.0									
Patient Lived Experience	3.2.1	Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from MDT reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4	Y		**Appendix 3.2.1 Medicine IPCC Chairs Report - Patient lived experience Appendix 3.2.2 3.2.1 Surgery IPCC Chairs Report - Patient lived experience**
	3.3.0									
IPC Campaigns	3.3.1	To educate all staff across the Trust on different campaigns including; Glove awareness, Bin the wipes, and the basic principles of IPC.	1,9	Matron IPC	Continue to promote best practice	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4	Y		**Appendix 3.3.1 Social Media Content. Appendix 3.3.2 Bin the wipe campaign communication. Appendix 3.3.3 ASF Learning bulletin 3.3.4 Bin the wipes campaign intranet link. Appendix 3.3.5 Infection Prevention and Control Week 2024 intranet link. Appendix 3.3.6 C. difficile Awareness Month 2024 Intranet Link**

				Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2024/2025	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2024/2025	DIPC	Q1	Y		**Appendix 4.1.1 IPC Teams report - September 2024**
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4	On track		**Appendix 4.2.1 SSI Knee April - June 2024. Appendix 4.2.1 SSI hip April - June 2024**
	4.2.2	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4	On track		**Appendix 4.2.2 CVAT IPCC October 24 - reports due May 25**
	4.3.0									
Patient Safety and Health Promotion	4.3.1	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Review themes and trends identified through PSIRF	DIPC / IPC Matron / Lead IPC Nurses	Q4	Ongoing		PSIRF has not been introduced for Gram negative bacteramia's due to a focus on the reduction of C. difficile. This action will be taken into the next financial year. ICB have set up task and finish groups from April to review gram negatives together this will be added to 25/26 annual plan.
	4.3.2	Standardise continence and bowel care services across the ICB	1,5,6,8	ICB Quality & Performance Specialist / IPC Leads across the ICB	Prepare a paper outlining how continence and bowel care is delivered across the ICB to highlight any differences in services and support a potential business case to improve patient care.	DIPC / IPC Matron	Q2	Ongoing		Within the ICB there has been prioritisation with Mpox, Measles, and emergency preparedness. Bowel care and continence workstreams have been put on hold. There has been no ICB collaborative meetings or updates from NHS England regarding this with the confimring that due to system pressures, this workstream was paused in Quarter 3. This action will be taken into the next financial year. ICB have set up task and finish group for bowel care from April 2025. This will be added to the new annual plan 25/26.
	4.3.3	Promote Hydration within the Trust	1,5,6,8	Divisional Nursing Directors	Divisional leads to report to IPCC in terms of progress on improving hydration. Educational information to be shared with patient partners.	Divisional Nursing Directors	Q2	Y		**Appendix 4.3.4 - Hydration Surgery Divisional monitoring**
	4.3.4	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Policy owner	Contribute to the review of the Urethral Catheterisation Procedure	DIPC / IPC Matron / Policy owner	Q1	Y		Trust policy has been updated. **Appendix 4.3.4 Urethral Catheterisation Procedure**
	4.3.5	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a Point Prevalence questionnaire for Divisional Leads to audit. Report findings to IPCC.	DIPC / IPC Matron / Divisional Nursing Directors	Q3	Y		Urinary Catheter audit to be added into AMAT. **Appendix 4.3.6 CAUTI proforma**
	4.3.6	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a list of actions in response to the Point Prevalence audit results which will include key messages to staff through safety bulletins	DIPC / IPC Matron / Divisional Nursing Directors	Q4	Ongoing		IPC Matron has met with Matron and Ward Manager of Ward 10 with the AMaT lead to review the current audits in place (3 audits in total) to combine into one audit. Work is ongoing to complete and also will include task and finish group from April with the ICB.
	4.4.0									
	4.4.1	Annual review of IPC audits.	1,2	Matron IPC / Lead Nurses IPC	Review and update audits to reflect current themes and trends identified.	Matron IPC / Lead Nurses IPC	Q4	Y		Hand Hygiene audit updated to include Glove awareness

Surviellance	4.4.2	Maintain a collective Trust-wide approach on diarrhoea and isolation compliance	1,2,4,5,7	DIPC / IPC Matron / IPC Data Analyst	Report compliance to IPCC on a monthly basis via IPC Team report	DIPC / IPC Matron / IPC Data Analyst	Q1	Y		Included in the IPC Teams report presented each month to IPCC.
	4.4.3	DIPC and Matron to continue Infection Prevention and Control Environmental checks	1,2	DIPC / Deputy Chief Nurse / IPC Team	Review estate and identify any environmental issues thast require urgent maintenance or repair.	DIPC / Deputy Chief Nurse / IPC Team	Q1,2,3,4	Y		**Appendix 4.4.3 IPC Walkabout schedule. Appendix 4.4.3 Escalation plan for IPC incidents (sewage)**
	4.4.4	Ensure IPC standardised signage is visible across the trust.	1,9	Matron IPC / Lead Nurses IPC	Complete an annual audit of IPC signage across the trust; Hand wash, Hand Gel, and outbreak signage.	Matron IPC / Lead Nurses IPC	Q1	Y		**Appendix 4.4.4 Clinic entrance hand gel audit RPH,CDH,CHH. Appendix 4.4.4 In-patient and Out-patient areas of stand alone hand gel. Appendix 4.4.4 In-Patient Hand Gel dispenser audit. Appendix 4.4.4 IPC signs around the trust. Appendix 4.4.4 Water safety across in-patient area. Awaiting audit and implementation from SCJohnson following the dissolution of Gojo.**
	4.4.5	Create a dashboard to have visibility of IPC compliance and infection rates at ward level.	1 2,6,9	Deputy Chief Nurse / Matron IPC / BI	Establish a data platform with BI which can be broken down departmentally to triangulate IPC compliance with infection rates to allow for priotisation for education and training.	Deputy Chief Nurse / Matron IPC / BI	Q2	Y		**Appendix 4.4.5 IPC Dashboard Update Appendix 4.4.5 IPC Dashboard BI portal**
	4.5.0									
Sepsis management improvement	4.5.1	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4	Y		**Appendix 4.5.1 Safety and Quality Sepsis Report. Appendix 4.5.1 Obstetrics Q3 Anonymoised report. Appendix 4.5.1 Q3 Anonymoised Report ED. Appendix 4.5.1 Q3 Master Report-Medicine. Appendix 4.5.1 Q3 Master Report-Surgery. Appendix 4.5.1 Q3 Paediatrics Anonymoised Report. Appendix 4.5.1 Q3 Sepsis Anonymoised Report**

		Ongoing Task			Milestone					
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Patient Saftey Inccident Reporting Framework	5.1.1	To identify, share and embed themes and trends to promote learning through incidents reported using PSIRF	1,4,6	DIPC	Produce processes for HCAI reporting and incident investigations.	IPC Team	Q1,2,3,4	Y		**Appendix 5.1.1 Process for Individual Hospital Associated Hospital Onset (HOHA) CDI cases. Appendix 5.1.1 CDI HOHA Learning review. Appendix 5.1.1 PSIRF MDT Learning Response Template CDI**
	5.1.2	Identify and themes and trends and promote learning following CDI MDT reviews	1,4,6	DIPC	Produce a quartely CDI outcome report identifying themes for learning to be presented at IPCC.	DIPC	Q1,2,3,4	Y		**Appendix 5.1.2 CDI PSIRF thematic review - Q1&2. Appendix 5.1.2 Surgical CDI thematic Review. Appendix 5.1.2 Medicine CDI thematic review**
	5.1.3	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	Deputy Chief Nuse	Demonstrate an improvement in the frequency of IPC incidents and complaints	IPC Data Admin	Q1,2,3,4	Y		The IPC related incidents are reviewed monthly and included as a standing agenda item for IPCC. **Appendix 5.1.3 IPC Datix Summary reports**
	5.1.4	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4	Y		All outbreaks are included as part of the IPC teams report presented each month at IPCC**. Appendix 5.1.4 IPC Teams reports**

Ongoing Task | Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide monthly reports to IPCC and the Trust Health and Safety Governance Group on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q1,2,3,4	Ongoing		**Appendix 6.1.1 WSG Chairs report - June 2024 6.1.1. Appendix WSG Chairs report - Sep 2024. Meeting frequency not in line with plan and reduced assurance in ths area with no formal report since Sept 2024. matter escalated to Director of Estates and a topic of priority for the estates and clinical partnership Board.**
	6.2.0									
Environmental and Equipment Cleaning	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	To be compliant with the National Cleaning standards of 2021 for 2024/2025	Head of Facilities	Q1, Q4	Ongoing		15 clinical areas are currently compliant with 60+ requiring implementation. An outline business case has been written with financial components. The risk at the moment is that a lot of the compliant areas are reliant on overtime/bank shifts and vacancies being filled. The additional investment is £737,000 per annum. From a board perspective there is a commitment to prioritise this. The paper will go to Trust Management Board then Board. If approved, it would be a phased approach over time as there is a lead time for recruitment, training, and implementation so would be done on a risk-based approach. **Approved next steps are to implement 50% by September 2025 and be 100% compliant by March 2026.**
	6.2.2	Monitor Estate and Facilities workstreams - Capital, maintenance, and cleanliness	2	Director of Estates & Facilities	Monthly Chairs report from the Estates and Facilities partnership board to be presented at IPCC.	IPC Matron	Q1,2,3,4	Y		**Appendix 6.2.2 Estates & Facilities Clinical Partnership meeting Chairs reports**
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions and IPCC on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC.	Hotel Services Manager / IPC Matron	Q1,2,3,4	Y		Presentation of monthly figures provided at each IPCC. **Appendix 6.2.3 IPC monthly cleaning summaries**
	6.2.4	To ensure cleaning and fogging is completed following CDI cases.	2	IPC Matron / IPC Data Analyst	Monitor compliance of fogging following CDI cases to reported to IPCC monthly in the IPC Teams report.	IPC Matron / IPC Data Analyst	Q1,2,3,4	Y		Fogging compliance following CDI Toxin cases is reviewed monthly and presented to IPCC monthly as part of the IPC teams report. **Appendix 6.2.4 IPC Teams reports**
	6.2.5	To ensure any improvement works are reviewed and prioritised from an IPC perspective.	2	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	IPC Matron to complete monthly walkrounds with Estates and Facilities to review the Estates from an IPC perspective and provide recommendations for best practice.	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	Q1,2,3,4	Y		Monthly walkrounds are being completed.
	6.3.0									
Decontamination	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Develop key metrics of data that must be monitored through IPCC relating to decontamination.	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Q1	Y		Fornightly meetings are being held with key stakeholders / Agenda item today
	6.3.2	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4	Y		**Appendix 6.3.2 NOV 2024 SSD REPORT**
	6.3.3	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4	Y		reports received & agenda item
	6.4.0									
Ventilation	6.4.1	Monitor ventilation across the estate.	1,2	Head of Operational Estates	Maintain assurances for ventilation via the Ventilation Working Group	Head of Operational Estates	Q2, 4	Y		**Appendix 6.4.1 Ventilation Safety Group ToR. Appendix 6.4.1 LTHTR Ventilation Safety Group Minutes. Appendix 6.4.1 VSG Action Log. Appendix 6.4.1 VSG Chairs report**

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Lead	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4	Y		**Appendix 7.1.1 Trust wide Antimicrobial Point Prevalence Audit Q1. Appendix 7.1.1 Trust wide Antimicrobial Point Prevalence Audit Q2. 7.1.1 Trust wide Antimicrobial Point Prevalence Audit Q3**
	7.1.2	Reduce the use of IV antimicrobials	3	AMS Lead	Monitor proportion of IV vs Oral antimicrobial use	AMS Team	Q4	Y		**Appendix 7.1.2 Consumption update Jan 2025**
	7.1.3	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q4	Y		**Appendix 7.1.3 Consumption update Jan 2025**
	7.1.4	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non-medical prescribing course.	Matron IPC & Lead Nurse	Q2	Y		IPC Lead Nurse has completed the course and is awaiting NMC pin update and completion of trust competencies.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
C. difficile	8.1.1	Reduce Hospital Acquired CDI	1,2,3,4,5,6,7, 8,9	Chief Nurse / Deputy Chief Nurse / DIPC	Monitor progress in the CDI Action Plan monthly at IPCC.	IPC Matron / DND's / Head of Facilities / Head of Estates	Q1,2,3,4	Y		The CDI action plan is discussed monthly at the E&F meetings in full with an update provided each month as a standing agenda item at IPCC. **Appendix 8.8.1 IPCC Agendas**
	8.2.0									
Norovirus	8.2.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Chief Nurse	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2	Y		**Appendix 8.2.1 Influenza.Norovirus end of year review - 202324 Appendix 8.2.1 Norovirus outbreak email**
	8.3.0									
Influenza	8.3.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Chief Nurse	Hold a multidisciplinary meeting led by Operations/Emergency preparedness team and report to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q2	Y		Occupational Health are promoting the Flu campaign from September 2024. The Influenza policy has been reviewed and is up to date. **Appendix 8.3.1 Influenza.Norovirus end of year review - 2023/24**
	8.4.0									
Measles	8.4.1	Ensure processes are in place for the potetnial risk of an epidemic of Measles.	1,2,3,4,5,6,7, 8,9,10	DIPC / Matron IPC / Divisional Nursing Directors / Clinical Directors / Deputy Chief Nurse	Hold regular multi-disciplinary Measles prepardness meetings with relevent actions monitored.	DIPC / Matron IPC / Divisional Nursing Directors / Clinical Directors / Deputy Chief Nurse	Q1,2,3,4	Y		**Appendix 8.4.1 Measles Action Tracker**
	8.4.2	Ensure trustwide policy, processes, and procedures are in place to maintain patient safety/	1,2,3,4,5,6,7, 8,9,10	DIPC / Matron IPC	Review and update the Measles policy and risk register accordingly.	DIPC / Matron IPC	Q1,2,3,4	Y		**Appendix 8.4.2 Policy tracker 2024/25**
	8.5.0									
XDR Multidrug resitant organisms	8.5.1	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2,3,4,5,6,7, 8,9	DIPC / Head of Estates / Head of Facilities / Augmented Care Leads	Hold regular meetings with Estates and Facilities and Augumented Care Leads to review and action findings identified in the external water expert report.	DIPC / Head of Estates / Head of Facilities / Augmented Care Leads	Q1,2,3,4	Y		**Appendix 8.5.1 Pseudomonas Action Plan**
	8.5.2	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2	Matron IPC / Lead Nurses IPC	Review the facilities in inpatient ward areas to ensure best practice is practical.	Matron IPC / Lead Nurses IPC	Q2	Y		Water Safety Group meeting
	8.5.3	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2,9	Matron IPC / Lead Nurses IPC	Review the distance between water basins and patient beds across inpatient areas.	Matron IPC / Lead Nurses IPC	Q2	Y		**Appendix 8.5.3 Sink distance audit in-patient.**
	8.6.0									
Emergency Preparedness	8.6.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q1,2,3,4	Y		**Appendix 8.6.1 Measles Action Tracker. Appendix 8.6.1 EPPR Policy**
	8.6.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	DIPC / Matron IPC	Provide education and updates on recent changes in National Guidance. Update any IPC Trust policies in accordance to changes	DIPC / Matron IPC	Q1,2,3,4	Y		

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	9.1.0									
Policies and	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4	Y		**Appendix 9.1.1 Policy Tracker 2024/2025**

Appendix 2

Infection Prevention and Control (IPC) Annual Programme 2025/2026

The annual programme for 2025/2026 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2024/2025. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of any new learning and shared good practice, is a key strategy to support the Annual Programme. The PSIRF process introduced in 2024/2025 continues to be strengthened. This process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) IPC Team Infrastructure 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Review of incidents & risks 6) Environment 7) Antimicrobials 8) IPC preparedness & Resillience 9) Policies & Procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning and communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Inter-relations / Wider Community / Strategic working	1.1.1	Support Task and Finish groups with the ICB colleuges	1,2,3,4,5,6, 7,8,9	Matron IPC / DIPC	Work collaboratively within the ICB providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3			
	1.1.2	Share learning from incidents across the ICB	1,2,7,9	Matron IPC / DIPC	Share any new learning with ICB in monthly IPC meeting	Matron IPC / DIPC	Q4			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive IPC education programme that follows national guidance	4, 6, 10	Matron IPC	To review and update the mandatory Infection Prevention and Control education in line with national guidance that's delivered to clinical and non-clinical staff	IPC Lead Nurses / Blended Learning team	Q4			
	2.1.2	Continue the Infection Prevention and Control face-to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Continue with education sessions for IPC across the Trust	IPC Team	Q1,2,3,4			
	2.1.3	Reduce reoccurring themes and trends identified in MDT reviews and/or outbreaks.	1,2,3,4,5,6,7	Matron IPC	Provide bespoke IPC training for departments following MDT reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3			
	2.1.4	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead / DND's	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead / DND's	Q1			
	2.1.5	Improve patient education on the importance of IPC principles	1,2,4,9	IPC Team / Patient Saftey Partners	Work with Patient Partners to improve patient's awareness of IPC principles to prevent cross-infection	IPC Team / Patient Saftey Partners	Q3			
	2.1.6	Improve Sbar to include red Triangle/ infection status/ Suspected infectious status	1,2,3,4,5,6,7, 9	IPC Lead/ IPC Matron	To Include patients infectious status in trust sbar	Divisonal Nursing Director Medicine	Q2			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via Trust comms, saftey bulletins, and social media	4,6	Matron IPC	Communicate Trust-wide regarding immediate safety and learning concerns, and celebrate good practice.	IPC Team	Q 1,2,3,4			
	3.2.0									
Patient Lived Experience	3.2.1	Share learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from MDT reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4			
	3.3.0									
IPC Campaigns	3.3.1	To educate all staff across the Trust on different IPC campaigns	1,9	Matron IPC	Continue to promote IPC best practice	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4			

Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory Infection objectives in the IPC Team report and Board papers for 2025/2026	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2025/2026	DIPC / IPC Matron	Q2			
Star Assurance Framework	4.1.2	To ensure IPC sections of star is reviewed annually	1,2	DIPC	To include a specific question regarding the decontamination of Medical devices between patients use	Quality Assuarance Matron/ IPC Matron	Q4			
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4			
	4.2.2	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4			
	4.3.0									
Patient Safety and Health Promotion	4.3.1	Improve intelligence and tackle contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Contribute to the ICB lead initiatives to reduce gram-negative bacteraemia.	DIPC / IPC Matron / Lead IPC Nurses	Q4			
	4.3.2	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a Point Prevalence questionnaire for Ward Matrons / Divisional lead to audit. Report findings to IPCC.	DIPC / IPC Matron / Divisional Nursing Directors	Q3			
	4.3.3	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a list of actions in response to the Point Prevalence audit results which will include key messages to staff through safety bulletins	DIPC / IPC Matron / Divisional Nursing Directors	Q4			
	4.3.4	Improve continence and bowel care across the ICB	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Contribute to the ICB led task and finish groups to improve continence and bowel care	DIPC / IPC Matron / Lead IPC Nurses	Q4			
	4.4.0									
Surviellance	4.4.1	Annual review of IPC audits.	1,2	Matron IPC / Lead Nurses IPC	Review and update IPC audits to reflect current themes and trends identified.	Matron IPC / Lead Nurses IPC	Q4			
	4.4.2	Participate in the national CDRN sentinel surveillance scheme which genotypes the 1st 10 CDI positive cases per month, to provide information on transmission	1,2	DIPC	Submit the 1st 10 CDI positive samples per month	DIPC	Q1			
	4.5.0									
Sepsis management improvement	4.5.1	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a quarterly report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4			
	4.5.2	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Patient Saftey Inccident Reporting Framework	5.1.1	Ensure that all HOHA CDI cases have a screeing tool completed	1,4,6	Divisional nursing directors or deputy	Ward managers and matrons to ensure that screening tool is completed within 7 days of case being reported	Ward managers and matrons	Q 2			
	5.1.2	Streamline the process for report gathering from CDI screening tool datixs for presentation at divisional IPCC meetings	1,4,6	Head of Risk & Datix Systems	Divisional leads to meet with the head of Risk & Datix Systems to develop the reports	Head of Risk & Datix Systems	Q 2			
	5.1.3	To identify, share and embed themes and trends to promote learning through CDI incidents reported using PSIRF	1,4,6	DIPC	Produce a bi-annual report that outlines themes of trends for CDI infection	DIPC	Q 1,3			
	5.1.4	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	DIPC	Complile a monthly report of Datixs for IPCC	DIPC	Q1,2,3,4			
	5.1.5	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide bi-monthly reports to IPCC on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q 1,2,3,4			
	6.2.0									
Environmental and Equipment Cleaning	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	To implement the national standards of healthcare cleanliness in a phased approach through 2025/26	Head of Facilities	Q1, Q4			
	6.2.2	Monitor Estate and Facilities workstreams - Capital, Maintenance, Remedial works, Waste, Cleanliness and Linen	2	Director of Estates & Facilities	Monthly Chairs report from the Estates and Facilities partnership board to be presented at IPCC.	Chair of Estates & Facilities partnership board	Q1,2,3,4			
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions and IPCC on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC.	Hotel Services Manager / IPC Matron	Q1,2,3,4			
	6.2.4	To ensure cleaning and fogging is completed following CDI cases.	2	IPC Matron / Head of facilities	Explore methods to monitor compliance of fogging following CDI cases to reported to IPCC monthly via facilities report (in the absence of the data analyst)	IPC Matron / Head of facilities	Q1,2,3,4			
	6.2.5	To ensure any improvement works are reviewed and prioritised from an IPC perspective.	2	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	IPC Matron to complete monthly walkrounds with Estates and Facilities to review the Estates from an IPC perspective and provide recommendations for best practice.	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	Q1,2,3,4			
	6.3.0									
Decontamination	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Develop key metrics of data that must be monitored through IPCC relating to decontamination.	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Q1			
	6.3.2	Ensure that there is a Trust decontamination lead	2	Director of Estates & Facilities	Ensure that there is a substantive Trust Decontamination Lead who has sufficient time to perform this role	Director of Estates & Facilities	Q4			
	6.3.3	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4			
	6.3.4	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4			
	6.4.0									
Ventilation	6.4.1	Monitor ventilation across the estate.	1,2	Head of Operational Estates	Provide bi-monthly reports from the Ventilation Working Group to IPCC	Head of Operational Estates	Q2, 4			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Lead	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4			
	7.1.2	Reduce the use of IV antimicrobials	3	AMS Lead	Monitor proportion of IV vs Oral antimicrobial use	AMS Team	Q4			
	7.1.3	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q4			
	7.1.4	To introduce penicillin allergy de-labelling guidance	3	ADIPC and AMS lead	Publish the guideline for implementation of penicillin de-labelling	ADIPC and AMS lead	Q3			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
C. difficile	8.1.1	Reduce Hospital Acquired CDI	1,2,3,4,5,6,7,8,9	Chief Nurse / Deputy Chief Nurse / DIPC	Monitor progress in the CDI Action Plan monthly at IPCC.	IPC Matron / DND's / Head of Facilities / Head of Estates	Q1,2,3,4			
	8.2.0									
Norovirus	8.2.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Chief Nurse	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			
	8.3.0									
Influenza	8.3.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Chief Nurse	Ensure the Influenza policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			
	8.4.0									
Candidozyma auris	8.4.1	Ensure processes are in place for the control of candidozyma auris	1,2,3,4,5,6,7,8,9,10	DIPC/Matron for IPC	Produce a trust IPC policy for candidozyma auris which follows national guidance	DIPC/Matron for IPC	Q 2			
	8.4.2	Ensure processes are in place for the control of candidozyma auris	1,2,3,4,5,6,7,8,9,10	DIPC / Matron IPC	Communicate and educate concern the new policy and procedures	DIPC / Matron IPC	Q 2			
	8.5.0									
XDR Multidrug resitant organisms	8.5.1	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2,3,4,5,6,7,8,9	DIPC/Matron for IPC	Communicate and educate concerning the policy for safe use of water on clinical areas	DIPC/Matron for IPC	Q 2			
	8.6.0									
Emergency Preparedness	8.6.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Matron	Q 4			
	8.6.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	Divisional nursing directors or deputy	Monitor and escalate any concerns relating to FFP3 fit-masking compliance	Divisional nursing directors or deputy	Q 4			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	9.1.0									
Policies and	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4			

Appendix 3

Clostridium *difficile* Improvement Plan

Version	Updated by	Date
1	S.Cullen/C. Gregory	29.2.24
2	S. Marsh	30.9.24
3	S. Cullen	2.10.24
4	S. Marsh	23.10.24
5	S. Marsh	21.03.25

Status Key	
1	Not complete
2	Actions on track to deliver within timescale
3	All actions complete but awaiting evidence
4	All actions completed and good supporting evidence provided

Area for improvement	Key Actions	Lead Executive Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1. Estate					
Management of the drain blockages	Focused campaign on reducing inappropriate items down the drain.	S. Marsh	15.3.24 30.4.24	Item in progress. Filming complete, signage on display in bathrooms and sluices. Meeting with procurement mid-March to review patient wipe products. 8.5.24- Campaign has now gone live	Bin%20the% Glove%20aw ASF Learning bulletin.pdf
	Need to check adequate disposal is available to reduce risk of wipes being put down toilets/macerators. Audit to be completed	S Marsh/S Fisher	31.5.24	Bin audit completed by IPC Team and updated waste manager.	
	Meet with NHS England IPC Lead Rosie Dixon to explore concerns relating to estate and how these can be managed.	D. Orr	14.2.24	Meeting held and agreed next action relating to site survey.	

	Undertake sewage site survey to understand the capital requirements to address the backup of the single sewage stack.	C. Howell	31.3.24	Survey commissioned. Report expected March 24. Update provided to say survey has been completed and report is now expected end of April so will review options on receipt of report.	
	On receipt of survey report (above) consider options for reduction of risk	Estates partnership board	30.4.24	New item added 10.4.24 Discussed at partnership Board	
	Drainage survey Report to be presented at execs for decision on next steps	C Howells	30.6.24	Survey report received and awaiting executive review. 3.7.24. Item complete. Being discussed with ICB for way forward David Levy and Sarah Morrison. Exploring alternative solutions	
	Bulletin for safety huddles refreshing bin the wipe campaign and highlighting macerator issues (number of bedpans and wipes and closure of lid)	S Marsh	5.6.24	IPC Leads circulates safety bulletin on the correct use of macerators.	
	List of old macerators to be circulated for prioritisation of replacement and triangulation with incidents	L Taylor	5.6.24	 Royal Preston Hospital Vernacare  Royal Preston Hospital Vernacare	
	Establish an escalation plan when sewage leaks occur on clinical areas to inform nursing leadership and the IPC team to respond appropriately.	S Marsh L Taylor	18.7.24	Escalation plan is currently in use	
Management of sink blockage and pseudomonas risk	Explore chemical options to reduce risk of pseudomonas.	D. Orr/S. Ashworth	1.2.24	Explore acetic acid and discounted due to health and safety management risk.	
		D. Orr	16.2.24	Visit completed, report received, and action plan created on recommendations. Regular meetings being held.	
Insufficient number of side rooms and reliance on redirooms	Identify a solution to address a lack of side rooms.	D. Orr	31.4.23	Point of Care faecal testing solution identified and funded as a cost pressure.	
Management of IPC related estate issues	Explore an alternative approach to addressing IPC risks in partnership with estates team.	S. Morrison	15.4.24	Discussion to be held following Northampton learning visit.	
Prioritise remedial works based on IPC risk.	Develop the Estates strategy for prioritisation of remedial works with IPC	L Taylor / S Marsh	~~30.8.24~~ 31.10.24	There is an IPC prioritisation mechanism based on risk with a set	

	support based on clinical risk.			criterion in place – verbal assurance in September IPCC.	
Consistent signage and hand wash – all entrances and sinks	Survey review to be undertaken by hand gel/wash provider and refreshed signage to be built into contract.	S. Marsh	~~31.5.24~~ ~~31.10.24~~ ~~30.11.24~~ 31.1.25 31.03.25	The IPC team have completed a walkaround to review all dispensers and signage as per the IPC Annual Plan 2024/25. New manufacturer site survey will commence w/c 29/05/2024 (SC Johnson). The implementation plan started in July and continues until the end of November. Further 1000 dispensers on order and signage to follow this. Plain dispensers then stickers will come. Children design in place. Signage above sinks confirmed and in place. SC Johnson installation is ongoing. No completion date despite this being requested. Plan also outstanding. SM to request this. 4.12.24 SC Johnson walk around completed, estates reviewing costing for painting, SC Johnson signs going up on Monday 16.12.24. 25.02.25 - SC Johnson continue with installation at CDH and CHH. Final installations at RPH. 18.03.25 - Shaun Ashworth agreed that the 35 side rooms outstanding will be installed by the internal Estates team.	
	Request Hand Gel holders for free-standing Gels for beds	S. Marsh	~~30.11.24~~	21/10/2024 – SM to discuss with procurement/supplies and ensure each inpatient area has sufficient holders on beds as per risk assessment. 28.01.2024 – SM and CG meeting with manufacturer to discuss signage and installation. 16.12.2024 – complete – SC Johnson have sent to supplies.	

STAR	Audit question to be included in STAR and assurance of signage compliance to be obtained.	S. Marsh/K. Dickinson	~~31.3.24~~ ~~30.4.24~~ 22.5.24	Confirmation received from QA matron that question added, assurance evidence required. Contacted K Dickinson and requested questions for evidence (Hand Hygiene, BBE, Daily Cleaning checklist, sewage incidents)	 IPC%20Ques
Failure to escalate leaks	Compete an escalation document	S Marsh L Taylor	29.7.24	Escalation document circulated	
	Develop a mechanism for confirmation that the pathway is followed.	L Taylor	30.8.24	Complete – verbal assurance of completion provided in September IPCC.	
	Conduct a Toolbox talk	L Taylor	30.8.24	Complete – verbal assurance of completion provided in September IPCC.	
2. Cleaning standards					
The trust is not compliant with national cleaning standards	Implement national domestic and nursing cleaning standards in 15 areas	J. Ashley	31.3.24	Completed in wards: Brindle, RWA, RWB, MAU, CrCu, 2a,20,21,23,24, 25 15,17,18,10 Audit evidence required, display results on entrance.	
	Implement nursing component of national cleaning standards in all areas.	C. Gregory	31.3.24 30.4.24 1.7.24	Completed Assurance evidence outstanding 22.5.24- compliance is improving and being monitored but no evidence of full compliance to date Further action- SM to meet with Liz Gleave for bank staff standardization of expectations Mandated field to be applied to STAR by the 1st July	 cleaning%2
	Identify resource required to implement national cleaning standards in wards non-compliant.	J. Ashley	15.2.24	Identified as a risk on the risk register. Identified as a cost pressure for consideration. Options appraisal considered by C FO/CNO – option 2 full compliance with wards and partial in non ward areas (outside of FR1) Value confirmed as £750k.	
	Provide rationale for required resource to implement cleaning standards.	J. Ashley	31.3.24	Following discussion with CFO/CNO rationale to underpin value of implementation costs required.	

	Review the standards/process of floor scrubbing – trial new battery-operated machines.	J Jackson-Bates / S Eccles	~~30.9.24~~ ~~31.10.24~~ ~~31.12.24~~	A trial is in place with a battery-operated machine – ongoing. Trial underway. 21.10.2024 – Not good feedback from user and ward staff due to noise and not fit for purpose. SE is reviewing other manufacturers with a view of trialing other products. JA requested SE to complete a risk assessment regarding cables. 18.11.24 – SE will forward trial outcomes to SM to embed here.	OCTOBER%20SLUICES.xlsx Sluice%20Planner.xlsx
	Implementation of national standards of cleanliness	C Gregory J Ashley	April 2025	21.10.2024 – a paper has been written regarding a phased approach to implementing the NSOC to the outstanding areas – This needs to be agreed at the board for funds. 18.11.24 – in draft and is awaiting approval. 16.12.24 – funds to be reviewed at the start of the new financial year. 25.02.25 - meeting to discuss 2025 version. Paper will be going to board 05.03.25. Funding has been approved and is going formally to the Trust Board on 5th April 2025.	
Implementation of Cleaning standards	Domestic management to recruit and train staff members in the national standards of healthcare cleanliness (NSOC) 2025 and the audit process.	L Cartwright / S Eccles	Ongoing	Recruiting for phase 2 of the implementation standards and training to be complete by the end of July 2025.	
	To implement the NSOC 2025 and roll out the cleaning standard in a phased approach starting with phase 2 ward areas FR1 / FR2	L Cartwright / S Eccles	August 2025	NSOC%20phased%20roll%20out.xlsx	
	To display the cleaning frequencies and star rating of all areas that have the	L Cartwright / S Eccles	August 2025		

	NSOC 2025 implemented as per phasing				
	To review the joint monitoring audits and ensure they are to 2025 NSOC standards and implement with agreed members to complete these each month.	L Cartwright / S Marsh / S Eccles	July 2025		
	Add the Joint audit compliance to the domestic monthly IPCC report for assurance.	L Cartwright	July 2025		
	To review the efficacy audits as part of NSOC 2025 and ensure IPC Team and Estates team support these with the domestics team in all FR1 and FR2 areas	L Cartwright / S Eccles / S Marsh	August 2025		
	Add the efficacy audit compliance to the domestic report for IPCC each month	L Cartwright	July 2025		
	Add UV sluice cleaning compliance to domestic report for IPCC each month	L Cartwright	July 2025		
Cleaning product selection	Implement sporicidal based cleaning product (Tristal jet) to replace red sporicidal wipes.	S. Marsh		Tristel jet selected. Now fully implemented in inpatient wards. Require evidence of reduced ordering and assurance if use in all areas.	
	Review approach to medical device cleaning and determine an agreed way forward.	S.Riley/D. Orr	15.2.24	Agreed to use Tristel jet on low-risk ward based medical devices.	
	Remove the green clinell wipes from routine practice to promote Tristel jet use in ward areas and reduce the presence of wipes that contribute to drainage issues.	S. Marsh	30.4.24	Green clinell wipes have been reduced in inpatient areas (still required for the cleaning of computers). Safety bulletin prepared and circulated via safety and learning. Tristel Jet use has been extended to include the most frequently used medical devices in Bays e.g., blood pressure machines etc.	
	Consider if ultraviolet light would enable improved compliance with deep cleaning of contaminated environments.	J. Ashley	31.5.24 14.6.24	Funding agreed to purchase three machines. 3.7.24 arrived last week. Team are doing training	
Assure appropriate decontamination and cleaning of dirty utilities.	Establish a process for clearing the sluice of items for access of domestic services to complete wall-to-wall and complete shelf cleaning.	DNDs / S Eccles	~~18.7.24~~ 15.10.24	A monthly sluice cleaning and UV decontamination plan in place to commence September 2024 – process being reviewed by facilities. Strengthened plan now in place 2.10.24	Review%20o

				to reflect daily, weekly and monthly cleaning of sluices including UV plan. Jason to provide the plan for this and this item will then be closed. 21.10.2024 – SM has discussed and shared the Sluice declutter plan at NMAHPs and has circulated a safety bulletin for sluices.	
	Develop the cost of applying National Cleaning Standards to dirty utilities.	L Cartwright	~~18.7.24~~ 31.10.24	Paper is being drafted by C. Gregory with Phases 2, 3 and 4 roll out for approval. Facilities have prioritised this. The sluices are compliant with national cleaning standards now.	
	Apply UV technology to decontaminate sluices monthly.	S Eccles	~~18.7.24~~ 30.9.24	UV training has been completed on the machines with an expected roll out in September 2024 – Facilities to update Plan in place reflected in actions above for cleaning schedules and frequency of sluices.	
	Explore the removal of yellow bins and linen cages from sluices and creating additional storage space.	S Ashworth	~~30.9.24~~ Outstanding date	Awaiting feedback – update from S. Ashworth and S. Fisher required. It has been requested for SF to complete an audit of the areas for scope of additional storage areas. This issue is primarily at RPH, CDH is broadly compliant. Completion date and plan for action required. This will need to address both waste and linen. 21.10.2024 – SE has asked Domestic staff to clean the yellow bins in addition to the storage on wheels in the sluice – comms to follow by SE. No update regarding additional storage space to date from waste or buildings manager. 18.11.24 – Domestic Team is cleaning high touch points of yellow bins daily. SM requested in Divisional IPCS for Divisions to identify areas with all services for communal storage area for bins and linen	

					waste. 16.12.24 – SM to raise in next month's IPC meetings. 25.02.25 - Sian Fisher advised she has reviewed areas and there have been no identified areas for storage space. 18.03.25 - Shaun Ashworth updated at IPCC that there has been a meeting and there will be a number of areas that will potentially be able to house the waste. This work is ongoing and Shaun will update at Partnership Board. 22.05.2025 – Waste manager completed review on both sites and implementation on waste stream will begin June 2025 education and training is being provided across the trust. Action complete.	
		Develop a Safety Bulletin for dissemination on the importance of cleaning and decluttering dirty utilities as well as what should and should not be stored (cardboard containers awaiting use).	D Orr S Marsh	~~30.8.24~~ 30.9.24	Audit of sluices completed. Awaiting completion of Safety bulletin.	Safety%20B
		Ensure that items that are not currently on any checklist are added (domestic cleaning) including wheelie bins, moveable platform for yellow cardboard bin.	S Eccles / J Jackson-Bates	30.9.24	Confirm raised platform on wheels are part of sluice cleaning requirements. This has been confirmed.	
		Consult with regional colleagues around the standard of cleaning macerators after each use	D Orr S Marsh	30.8.24	Audit completed on macerators across both sites. Discussions with neighboring Trusts who do not clean after each use unless visibly contaminated.	
	The process and oversight for fogging areas requires strengthening.	Process to be reviewed, strengthened and documented.	C. Gregory	31.1.24	App created and access now in place. Evidence of discussion in patient flow meetings.	
		Access to BI app for all Matrons, Trust Operational Officers, Divisional nurse and Midwifery Directors.	C. Gregory	12.2.24	Trust Operational Officer and Matrons have accessed, this has been checked and confirmed.	

		Evidence that the revised process is leading to less delays.	S. Marsh	30.4.24	Fogging compliance report in IPC Team report for IPCC each month tracking compliance and any outstanding areas. Escalation plans with decant facilities being utilized at weekends to ensure fogging is completed within set timescales. Outstanding fogging requests are escalated daily at the Bed management meetings as an agenda item.	
		Explore decontamination options for areas such as dirty utilities, storerooms, bathrooms and toilets with no electrical points.	S Eccles	~~30.8.24~~ ~~30.9.24~~ ~~15.10.24~~ ~~15.11.24~~	Communications are ongoing with Inivos to find a suitable battery pack as the ones previously looked at do not have enough power. No update available. Deadline extended. 21.10.2024 – SE to discuss with the rapid response team to work out the number of areas which require the battery packs. 18.11.24 – SE to walkaround RPH to identify areas that require sockets. 16.12.24 – awaiting information to be forwarded from SE.	
		Investigate how to keep pending cleans open on the BI app so Bed Management are aware of what fogging is outstanding.	S Eccles	24.10.24	1.10.2024 – SE advised that domestic team are not removing pending items. IPC team continue to request as per policy. 18.11.24 – SE to query with IT and BI for requests only to be deleted / removed by Domestic Managers. 16.12.24 – Update from JA – this has now been completed.	

	Declutter and standardize items	Action changed to work with improvement team to consider roll out of well-organized ward component of productive ward.	DNDs	~~31.12.24~~ 28.02.24 30.04.25	SC made request of the improvement team to implement productive ward foundations as part of the next phase of MCA. Update 31.10.24 21.10.2024 – CG to discuss with Continuous Improvement team. 16.12.24 – SM to contact Jennifer Carroll as actioned in meeting. 25.02.25 - continuous improvement team will be reviewing items for standardisation across ward areas. 22.5.25- assessment has been completed and priorities agreed. Work has progressed as much as practicable within this timeframe	
3. Compliance and assurance oversight						
	Strengthened oversight of triangulated IPC metrics.	Agree the key metrics that provide increased assurance on IPC processes.	C. Gregory	30.11.23	Metric agreed. Manual plan in place to take to IPC committee in March.	
		BI solution to the IPC dashboard required.	P. Capps	~~31.5.24~~ 11.10.24	21.10.2024 – IPC Dashboard is now live with access to all. SM has asked the BI team to showcase this again at NMAHP's. 18.11.24 – SM shared at Partnership Board. Link distributed in the meeting minutes and all relevant colleagues to start accessing dashboard.	
	IPC policy should reflect the strengthened assurance and oversight mechanisms in place for IPC.	IPC policy (C. difficile) to be updated to reflect the strengthened arrangements.	D. Orr/ C. Gregory	~~31.5.24~~ 31.8.24	Updates completed – awaiting ratification	
		IPC policy to be updated to reflect the strengthened arrangements	D. Orr/S. Marsh	31.1.24 30.04.25 30.8.25	IPC policy scheduled for review in Jan 24. 21.10.2024 – DO and SM will link in with colleagues across ICB to see if they have an overarching IPC policy. 16.12.2024 – Draft policy sent to CG	

					and SM for comments and approval. 21.03.25 - Sent to CG for review and feedback. 22.5.25- under review and draft insertion of strengthened assurances. For ratification at June's IPCC	
	Review the Uniform policy in line with IPC principles	Review the Uniform policy in line with IPC principles	C. Gregory S. Marsh	31.1.25 30.04.25 30.8.25	16.12.2024 – Under review 22.5.25- extension granted whilst consultation with staff and colleagues from staff engagement forums. Due for completion end June 2025	
	Strengthen the Ward specific whiteboard to include infectious status	Strengthen the ward specific whiteboard to include information on the red triangle	D. Orr	~~31.1.25~~ 28.02.25 30.04.25	25.02.25 - BI Team unable to complete this task at present due to other work priorities. It has been agreed to remove this action as the electronic patient record does include the infection status of the patient.	
	The C. *difficile* risk should be updated to reflect the enhanced actions taken in response to raised incidence.	The risk should be reviewed and reflect the additional actions taken.	C. Gregory	26.2.24	Completed and recommended risk is escalated to a score of 20 and considered for Board escalation. SQC accepted this and have escalated risk to Board.	
	The assurance data should reflect the dual approach to cleaning standards compliance 2018/2021.	The presentation of compliance data requires revision due to partial implementation of cleaning standards.	C. Gregory	31.5.24	From new 2024/25 performance pack the data will be disaggregated to demonstrate compliance with 2018 and 2021 cleaning standards. 3.7.24 Tested approach in surgery and will go to S and Q in July 18.09.2024 - A financial funding paper has been drafted with a phased approach. 2.10.24 – Reporting now in place. Requested quality audit standards are included in the SQC report going forward. SC to request this form Nicola Ross.	
	Review of STAR metrics and mandatory field	Incorporate cleaning checklist and other	S Marsh/ J	31.5.24	Training with plumbers due to	

		standards as mandatory fields	Howles		commence. SOP to be developed with clear roles and responsibilities. STAR team are reviewing cleaning and discharge checklists on accreditation visits. 3.7.24 This is mandatory from the 1st July 2024	
	Review Joint monitoring audits	Review the joint monitoring audits to: • Standardise the areas of the ward that are being monitored and include high risk areas. • Standardise the questions in the monitoring so that there is assurance of "wall to wall floor cleanliness" and high touch point areas including shelves and wall mounted dispensers/holders. • Review the daily and weekly supervisor review	J Tonge / S Eccles	30.7.24	Complete	
	Review IPC revalidation audits	Review the IPC revalidation audits to: • Standardise the areas of the ward that are being monitored and include high risk areas. • Standardise the questions in the monitoring so that there is assurance of "wall to wall floor cleanliness" and high touch point areas including shelves and wall mounted dispensers/holders.	IPC Lead Nurses	30.9.24	All IPC revalidation audits have been reviewed and updated on AMAT.	
4.	**Training and Education**					
	Strengthen evidence of specific housekeeper training and arrangements for when the housekeepers are absent.	Housekeeping Training Needs Analysis to be created with specific housekeeper training curriculum developed.	S. Marsh	31.1.24	Housekeeper training is completed for all departments across the organization. The IPC team will continue to support this education with HCA's, volunteers and will strengthen patient education as part of the IPC Annual Plan 2024/2025.	Housekeepe Housekeepe
		TNA to be agreed with education and this forms part of the role specific	S. Marsh /C. Taylor	~~31.3.24~~ 31.4.24	S Marsh has provided a list of staff members who have completed the	

	training reports.			training. Awaiting response confirmation tat this has been added to TNA.	
	IPC assurance of training implementation is visible in practice.	S. Marsh	31.3.24	IPC team continue to support wards and departments with bespoke training and revalidation audits.	
IPC training should reflect the increased vigilance required around C.difficile prevention.	Review of IPC training and confirm it contains the required content for the correct audience.	S. Marsh	~~31.3.24~~ 31.4.24	The IPC E-learning package has been reviewed and updated, awaiting a live date from the Blended Learning team. The DIPC has reviewed this with IPC Matron and are happy with the content and confirm it is in line with the National IPC framework for education. Confirmed went live on the 29th April	
Increase IPC awareness and staff responsibility.	Trust Staff face-to-face induction to include an IPC slot for each session.	S. Marsh	31.1.25	21.10.2024 – SM to contact relevant persons to include IPC in induction sessions. 25.02.25 - not approved by LE. 22.5.25- unable to progress. Action closed and will continue with current training provision with evidence of compliance	
5. Movement around the hospitals					
The practice of beds being used to push patients around the hospital increases the risk of shedding of spores.	Review the approach to this and communicate expectations to minimize movement of beds unless clinically indicated.	S. Marsh	30.9.24	Communication prepared and completed.	
	Establish an approach to monitoring this.	J. Ashley	31.1.24	Measurement system in place for both CDH and RPH.	
	Establish what expected parameters would look like and add to the IPC dashboard.	J. Ashley	~~31.3.24~~ ~~11.10.24~~	The expected levels of activity should be articulated, included in the IPC dashboard to ensure activity stays within upper and lower control limits. BI Dashboard should be completed by 10th October. Addressed in the dashboard due to launch 11.10.24 21.10.2024 – IPC dashboard is now live; the divisions will now be able to view patient transfers	

6. Integrity of equipment					
Mattress integrity is variable when tested. This requires improvement.	Audit approach should be reviewed with training and approach and strengthened.	N. Ross	31.11.24		
	Mattress audit data to be added to the IPC dashboard.	C. Gregory	~~31.3.24~~ 10.10.24	BI Dashboard should be completed by 10th October Addressed in the dashboard. Due to launch 11.10.24 21.10.2024 – IPC dashboard is now live; the divisions will now be able to view Mattress audit data at ward level	
Move to white only aprons in pandemic has removed a prompt to change aprons and limits the ability to challenge poor practice.	Return to colour themed aprons.	S. Marsh/J. Ashley	31.5.24	Coloured aprons in circulation across the Trust and being used.	
7. Antimicrobial use					
Review the use of Cefuroxime due to connection to C. difficile and high consumption noted.	Guidelines to be reviewed to consider alternative.	D. Orr	30.11.24	Antimicrobial guideline reviewed and changed to reduce consumption of Clarithromycin.	
	Review sepsis guideline with specific focus on sepsis of unknown origin.	C. Roberts	31.12.24	Guideline reviewed and focus on sepsis of unknown origin has resulted in a communication campaign to reduce this diagnosis description.	
8. Patient and family engagement and information					
Review of information to patients pre, peri and post admission.	Patient Safety Partner to lead this review and make recommendations.	C. Gregory	31.5.24		
Review of information provided to family regarding infection control on entrance to the hospital start to end of the journey.	Patient Safety Partner to lead this review and make recommendations.	C. Gregory	31.5.24		
9. Learning from previous incidents to improve patient care (PSIRF)					
Learning from incidents highlights Improvements needed to compliance with hand hygiene audits	Develop IPC dashboard with key metrics. Focus on improvement via Matrons assurance reports and IPC dashboard.	C Gregory DNDS	~~31.5.24~~ 11.10.24	BI Dashboard should be completed by 11th October 21.10.2024 – BI dashboard went live on 11.10.2024 and BI team will showcase at NMAHPs so leads can start to use this for their areas. There will be further additions to the dashboard.	
Learning from incidents highlights improved compliance is needed with documented risk assessments and care plans	As above	C Gregory DNDS	31.5.24	As above	
Learning from incidents highlights that	As above	C Gregory	~~31.5.24~~	As above	

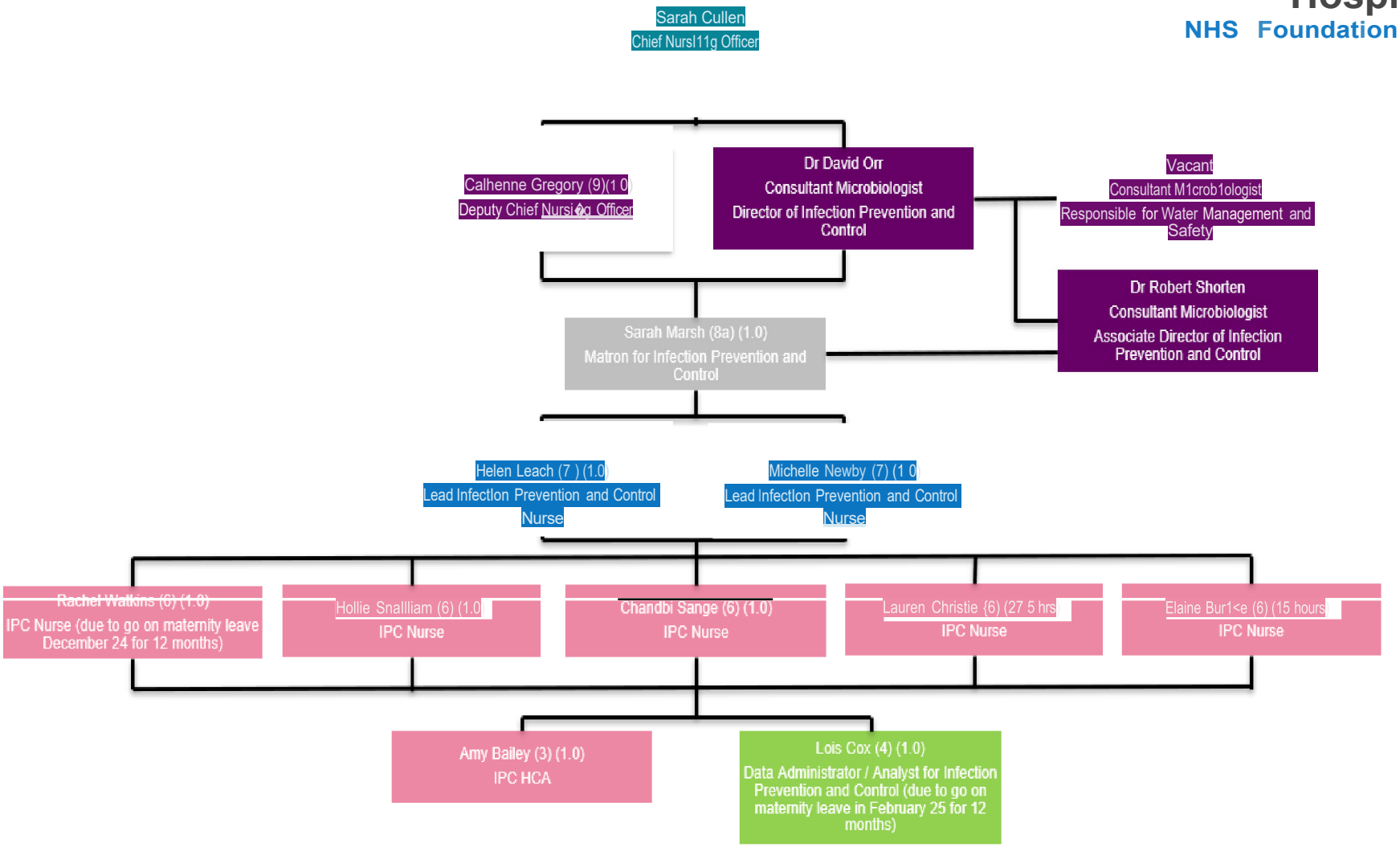
improve compliance is needed with commode audits		DNDS			
Learning from incidents highlights opportunity to reduce delays in time to isolation	As above	C Gregory DNDS	11.10.24	As above	
Learning from incidents highlights opportunity to reduce delays in sampling	As above	C Gregory DNDS	~~31.5.24~~	21.10.2024 – As part of PSIRF MDT reviews and also the Datix screening tool, outcomes are shared. Datix incidents are available on the IPC Dashboard.	
10. Research and innovation					
Partake in research regarding hand hygiene		D Orr and S Marsh	October 2024 Ongoing	The Primel study commenced in October 2024 reporting good results with national/international importance. Further studies are being investigated.	
End of Action Plan					

Action Plan Sign Off
Name: Sarah Morrison
Date:

Appendix 4

Infection, Prevention and Control Team

Lancash"re Teaching Hospita s
NHS Foundation Trust



All post are 1 x WTE unless stated

Appendix 5

Excellent care with compassion

Agenda

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Community of Practice

Friday 11 October 2024 | 09:30 – 15:00
Lecture Hall | Health Academy 1 | Royal Preston Hospital

Topic of the Day: Securing safety in frontline defence: Best practice in IPC standards

#	Item	Time	Owner
	Morning session		
1	Welcome to the Community of Practice	09:30	Sarah Cullen
2	Setting our vision, aims and objective and collective leadership	09:40	Catherine Gregory aims%20and%20objectives%20CG.pptx
3	Best practice in IPC standards	10:10	Sarah Marsh IPC%20Away%20Day%20Presentation%
	10:55 Coffee break		
4	Sharing examples of best practice	11:10	GOLD star areas c%20diff%20presentation%20October% CDIFF%20Presentation%20FINAL.pptx
5	Matrons, AHP Professional Leads and Ward / Unit Managers Responsibilities	11:40	Rachel Sansbury Community%20of%20Practice%20IPC%2
6	IPC Dashboard and providing assurance. What does good look like?	12:00	Percy Moyo / Sonsoles Acosta Ubeda IPC%20Dashboard.pptx
	12:30 Lunch break		
	Afternoon session		

7	Break out workshops • Library IT Suite | HA1 • Seminar 7 | HA1 • Meeting Room 2 | HA1 • Meeting Room 1 | HA1	13:00	Facilitated by DNDs, deputies, Chief AHPs and deputy CNOs
8	Feedback	14:00	all
9	Setting our Commitments to Practice	14:30	all
15:00 Close			

Next meeting: TBC

11.2 WINTER PLANNING

Other | K Foster-Greenwood | 2.15pm

Item for Assurance

REFERENCES

Only PDFs are attached

11.2 - Winter Planning Assurance report 2526.pdf

Council of Governors Meeting

Winter Board Assurance Statement			
Report to:	Council of Governors Meeting	**Date:**	18.09.25
Report of:	K Foster Greenwood	**Prepared by:**	K Foster Greenwood

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

Executive Summary:

Executive Summary: Winter Board Assurance Statement

Winter Planning 2025/26: Lancashire Teaching Hospitals Trust has conducted a surge management assessment for the winter of 2025/26 to ensure sufficient capacity to meet non-elective winter patient demand without compromising planned care services 6. Data modelling suggests that the unmitigated impact of winter surges in demand could lead to a deterioration of between 0.5-4.5% and an increased bed demand of between 9-69 beds, with the largest increases predicted in November 2025 and January 2026

Mitigation Schemes: A plan has been developed to support the mobilisation of mitigation schemes aimed at reducing ED attendances, admissions, bed occupancy/LOS, and improving patient discharge flow. The schemes will be monitored monthly, and any scheme failing to deliver the required outcomes will be considered for cessation, with investment redirected to alternative schemes. Funding of £800K has been identified to support surge management in 2025/26.

High-Impact Schemes:

1. Additional Paediatric medical capacity
2. Increased discharge lounge capacity
3. ED transfer team
4. Extended SDEC provision
5. Respiratory assessment provision
6. Additional medical staffing for AMU
7. Medical outlier team
8. Additional winter bed capacity

Additional Lancashire and South Cumbria wide Schemes Supported by UEC Capacity Investment Programme include:

1. Therapy admission avoidance service at Chorley District Hospital.
2. Hospice at Home.

3. Care Connexion.
4. Virtual Wards.
5. Long Term Conditions - Local Enhanced Service.

System Engagement and Stress Testing: NHS England has required all provider organisations and ICBs to undertake a Winter Planning submission, which has been assessed and stress-tested 24. The LTH plan has been developed in conjunction with Central Lancashire system partners.

Board Assurance: NHS England requires Boards to undertake an Assurance Assessment and submit a statement to ensure Board-level oversight by 30th September 2025.

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

Winter Planning 2025/26

Lancashire Teaching Hospitals Trust has undertaken a 25/26 surge management assessment to ensure that there is sufficient capacity to meet the non elective winter patient demand without compromise to planned care services.

Data modelling suggest that the 'unmitigated' impact of winter surges in demand would likely be a deterioration of between 0.5-4.5%with an increased bed demand of between 9-69 beds. (Ranges are based on demand by month with the largest increases in demand predicted to be in November 25 an Jan 26.

Subsequently a plan has been developed which supports the mobilisation of mitigation schemes aimed at reducing ED attendances, admissions, bed occupancy/LOS and improving patient discharge flow. Schemes have been assessed against their impact on the aforementioned aims, cost and ease of mobilisation.

All schemes will be monitored monthly and any scheme which fails to mobilise or deliver the required outcomes will be considered for cessation and investment will be directed to alternative schemes.

Funding of £800K was identified to support surge management in 2025/26. The following schemes have been identified as being of the highest impact and include:

Scheme Detail	Duration	Outcome	Cost
Additional Paediatric medical capacity	5 months	Reduced waiting times within ED and PAU 4 hour breach prevention Increased timeliness of discharge/reduced LOS	£133,064
Increased discharge lounge capacity	5 months	Earlier admission to AMU ED overcrowding reduction Reduced 12 hour+ LOS	£57,037
ED transfer Team	5 months	Reduced ED overcrowding Reduce ambulance handover breaches	£24,945
Extended SDEC provision	6 months	Reduced admissions Reduced ED overcrowding Reduced ED attendances Improved 4 hour ED performance	£60,565
Respiratory Assessment provision	5 months	Increased capacity to reduced ED overcrowding Reduced LOS Increased admission avoidance Improved 4 hour ED performance	£97,690
Additional Medical Staffing AMU	5 months	Increased weekend discharge rate Reduced evening overcrowding in ED Reduced LOS.	£90,007
Medical Outlier Team	4 months	Reduced LOS for outlying patients Increased bed capacity Reduced 12 hour+ED LOS.	£115,600
Additional winter bed capacity	6 weeks	Reduce 12 hour+ ED LOS Reduce ED overcrowding	£179,000
Total			**£804,638**

In addition within L&SC a UEC Capacity Investment Programme supported the mobilisation of additional schemes to support the management of increased demand. The schemes which would provide additional resource to Central Lancashire include:

Initiative / Scheme	Duration	Description	Go-live Date/Timescale for Implementation
Therapy (Chorley District Hospital	12 Months	Therapy admission avoidance service at Chorley District Hospital.	1 April 2025 – 31 March 2026
Hospice at Home	12 Months	St Catherines Hospice - provide hands-on personal care, psychological support for patients and their families.	1 April 2025 – 31 March 2026
Care Connexion	12 Months	Expansion of single point of access/care navigation/transfer of care hub for Central Lancashire.	1 April 2025 – 31 March 2026
Virtual Wards	12 Months	Allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery whilst freeing up hospitals beds for patients that need them most.	1 April 2025 – 31 March 2026
Long Term Conditions - Local Enhanced Service	12 Months	To ensure those patients with an existing diagnosis of COPD and asthma who are at highest risk of worsening respiratory health and most likely to exacerbate are identified and offered a Holistic Health Assessment to ensure their respiratory care is optimal.	1 April 2025 – 31 March 2026

System engagement and Stress Testing

NHS England have required all provider organisations and ICBs to undertake a Winter Planning submission which has been assessed and subsequently a regional Winter Planning Exercise was held to stress test each plan.

The LTH plan has been developed in conjunction with Central Lancashire system partners.

Board Assurance

NHS England require Boards to undertake an Assurance Assessment and submit a statement to ensure Board level oversight. This is required to be submitted by 30th September 2025.

12. STRATEGY AND PLANNING

12.1 SINGLE IMPROVEMENT PLAN

Information Item | A Brotherton | 2.25pm

REFERENCES

Only PDFs are attached

12.1 - COG SIP Update Sep-25.pdf

Council of Governors

SIP update Sep 25/26							
Report to:	Council of Governors			**Date:**	30/10/25		
Report of:	Chief Strategy & Improvement Officer			**Prepared by:**	K Marshall		
Purpose of Report							
For assurance	☒	**For decision**	☐	**For information**	☐		

Executive Summary:

The purpose of this report is to provide an overview of the September 2025 delivery position for Single Improvement Plan (SIP) and progress to improve the governance and alignment of the SIP into Trust business.

The NHSE Recovery Support Programme Team (RSP) observed the SIP portfolio structure and reporting, making recommendations including improved standardisation and rigour across portfolios and a focus on non-delivery at programme level. Changes that have been enacted include –

- Inclusion of Trust Management Board membership within the SIP Oversight board to improve visibility
- Inclusion of SIP overview within the Integrated Performance Report presented to Trust Board
- Review of governance arrangements within each portfolio

From August to September there has been slippage in milestone delivery with an increase in overdue milestones, increase in upcoming milestones not yet started. Delivery is closely monitored through each portfolio and escalated to the SIP Oversight Board. Work is underway to reduce potential slippage of overall delivery and enact mitigations where required.

A key set of enablers has been agreed within the SIP Oversight Board to focus on successful delivery of SIP outcomes. This includes data visibility and intelligence, rigour and governance to SIP monitoring, Senior Leadership Team development, Trust strategy that all create foundations of an optimal environment to be successful in delivery of the level of improvement required across the organisation through the SIP.

The SIP, supported by the revised accountability framework, remain the vehicle for delivery of the Trust's main programmes of work and oversight within the organisation. The criteria remain challenging to deliver within the operational and financial pressures facing the Trust and the wider system.

It is recommended that the committee:

I. Note the delivery position of the SIP for Sep-25 and key outcome metrics position.
II. Note the development of SIP maturity to embed into the organisation.

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	☒

1. Background

In April 2024, Lancashire Teaching Hospitals developed and implemented a Single Improvement Plan (SIP) with the aim to align and focus improvement efforts across the Organisation in a 3-year strategic plan. For 2025/26 plans include a focus on areas of continued challenge to deliver outcome improvement alongside financial improvement. Detailed deliverables are included for information in the appendix.

2. Discussion

2.1 Delivery Overview

From August to September there has been slippage in milestone delivery with an increase in overdue milestones, increase in upcoming milestones not yet started. Delivery is closely monitored through each portfolio and escalated to the SIP Oversight Board. Work is underway to reduce potential slippage of overall delivery and enact mitigations where required. Please see SIP delivery dashboard below.

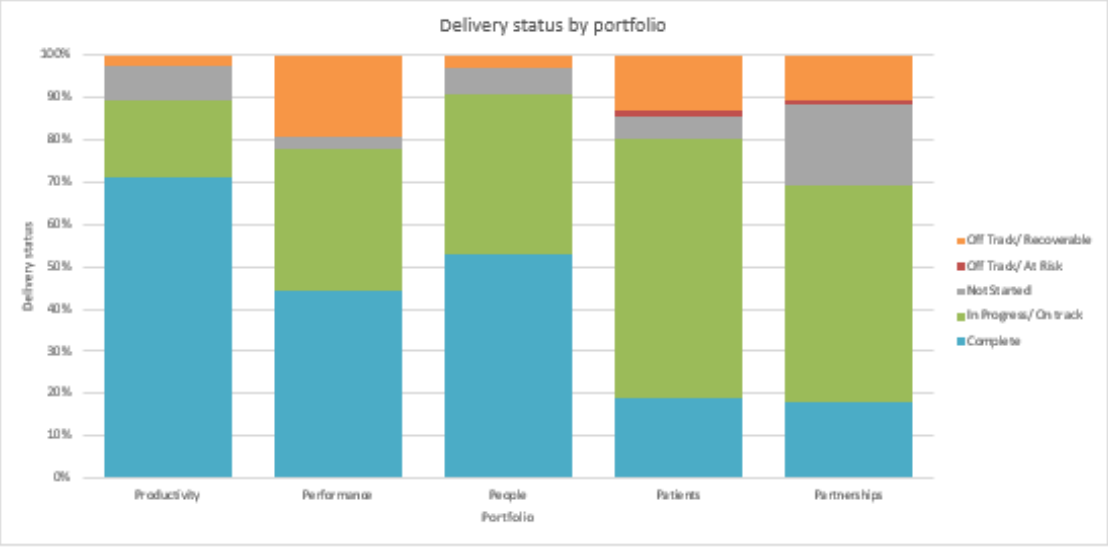
Key programmes as listed below are in need of review and reset where appropriate to consider if the correct actions are in place and what is deliverable in year. These are programmes that have had slippage and milestones off track for more than 2 months.

Patients - Health Inequalities, Safe Staffing, Always Safety First,
Performance - UEC, Diagnostics, Outpatients
People - Appraisal
Productivity - Procurements & Contracts
Partnerships - Governance & Risk, Health & Safety, Planning, Information Improvement

These will be reviewed and updated by each programme lead and agreed through each portfolio board. Although monitoring and adherence to delivery dates is required to ensure delivery does not slip throughout the year we also needs to remain agile in delivery to be able to respond to needs and priorities of the Organisation. The Green Plan will be included within the Partnerships portfolio to improve visibility and oversight of this key programme.

Single Improvement Plan| Delivery dashboard 2025-2026

Reporting Period: Sep-25



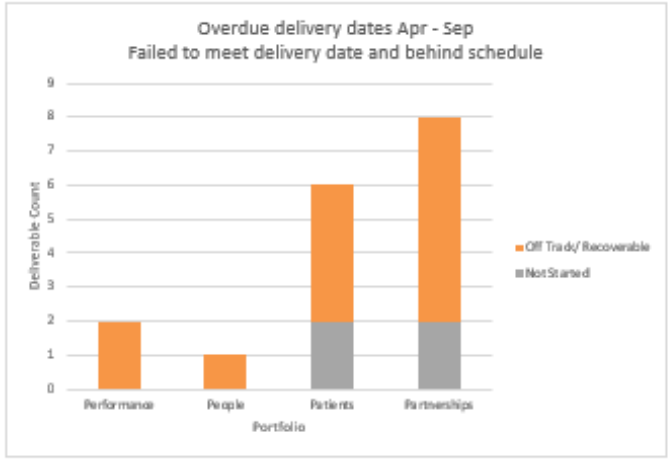
Movement since last period

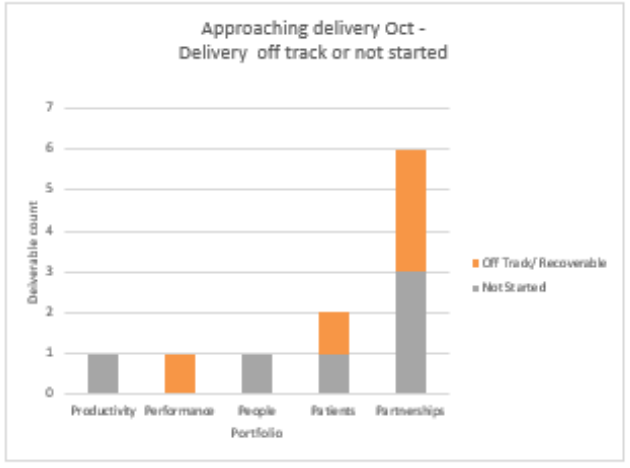
Increase in overdue milestones (Apr-Sep delivery dates) that are not yet showing as delivered shown in table by portfolio and programme.

Increase in upcoming period delivery that are not in progress/complete and showing as off track or note started.

2 milestones flagging as at risk of not delivering to timeframe in Performance and Patients portfolios.

Key programmes in need of focus on delivery plans -
Patients - Health Inequalities, Safe Staffing, Always Safety First,
Performance - UEC, Diagnostics, Outpatients
People - Appraisal
Productivity - Procurements & Contracts
Partnerships - Governance & Risk, Helath & Safety, Planning, Information Improvement





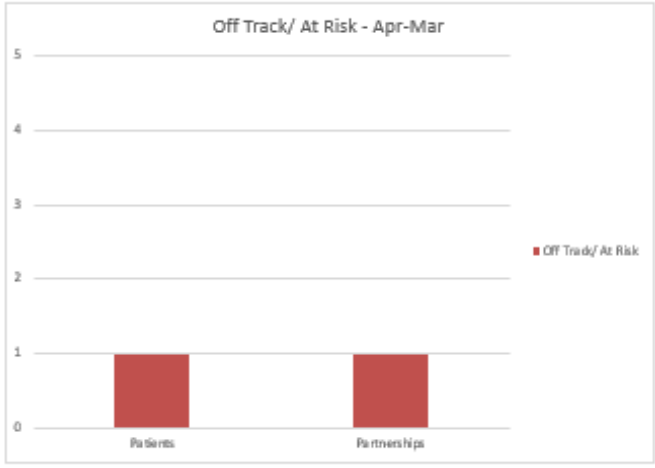


Figure 1. SIP delivery dashboard - Sep-25

2.2 SIP Outcomes

Detailed metrics are monitored through each SIP portfolio. A key performance indicator (KPI) matrix in table 1 below shows position of key metrics and correlation between the performance of metrics across portfolios.

Areas that have consistently flagged as failing to meet target throughout this period are within performance measures and people measures. Metrics showing a recent concerning pattern in the data where metrics will fail to meet target include:

- Staff survey measure recommending the Trust as a place to work,
- Performance measures including metrics for elective care, urgent emergency care and cancer care.

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 that 18 weeks - Bed occupancy to 90% - 31 Day Cancer Standard - Cancer 62-day performance	- RTT - 52 week Waiters - Cancer Faster Diagnosis Performance	
Normal variation - no recent change	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Maximum wait of 12 hours as Total Time in Dept - RTT - 65 Week Waiters - Reduce not meeting criteria to reside (DKAFH) - Number of boarded patients - Vacancies (% FTE) - Staffing Fill Rate Maternity Support Worker	- Pressure Ulcers per 1000 beds days (Category 2 and above) - 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 - Perinatal - Number of Stillbirths - 85% theatre utilisation - aggregate - Capped - Turnover (% FTE) - Number of violence and aggression incidents toward staff	-PIFU Rate - Staffing Fill Rate Registered Nurse - STAR Accreditation all trust (Silver and Above)
Recent positive pattern in the data	- Compliance with 60 minute ambulance turnaround time target - Percentage of patients that receive a diagnostic test within six weeks	- Sickness Absence (% FTE)	

Non SPC Metrics flagged as a concern
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
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	9 out of 10 are on track

People
Patients
Productivity
Performance

Table 1: SIP KPI matrix Sep-25

2.3 Governance

Informal feedback from the NHSE RSP team observations includes improving standardisation and rigour across portfolios and a focus on non-delivery at programme level. To improve visibility the SIP Oversight Board has been expanded to include all Trust Management Board members.

SIP Governance Structure

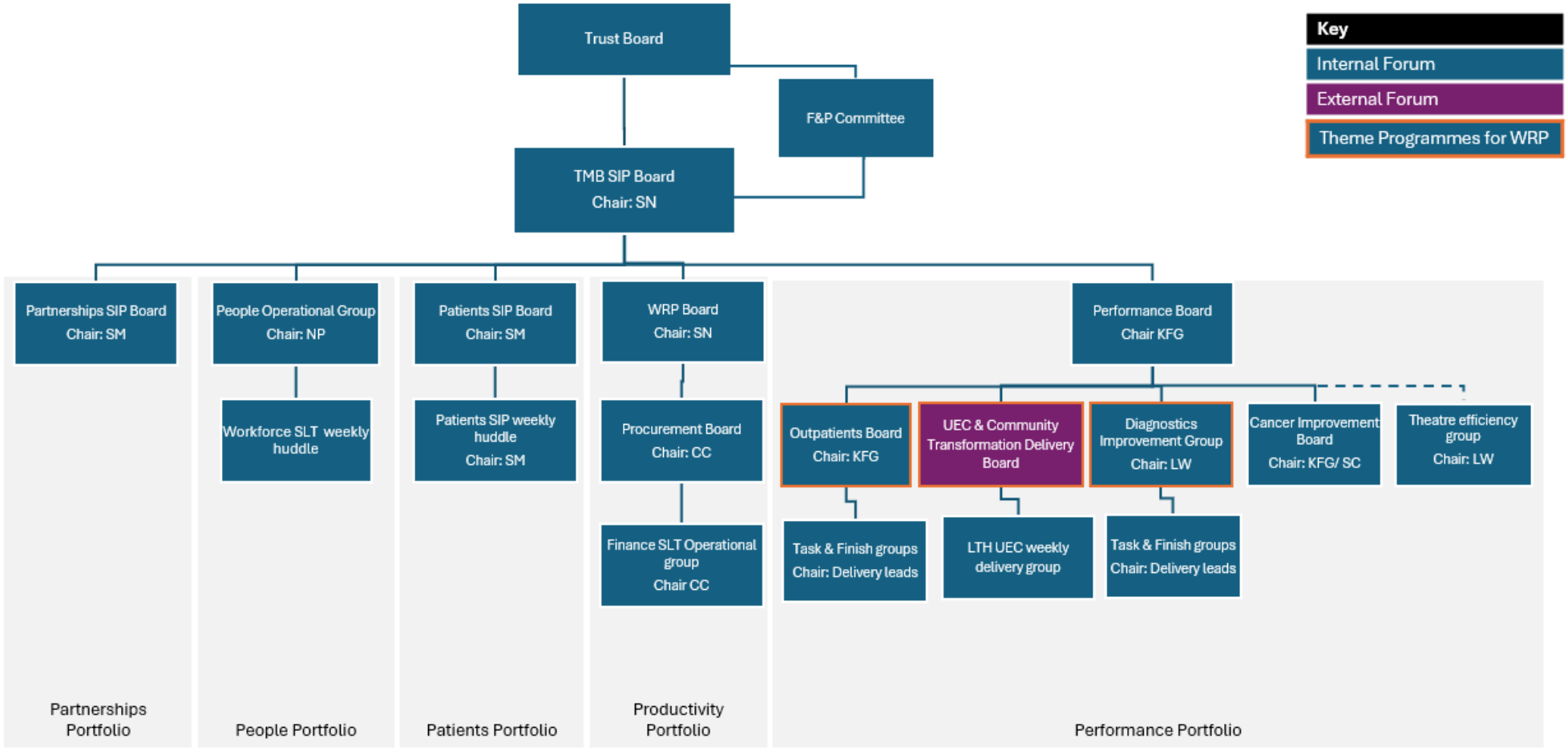


Figure 2. SIP Governance Structure

2.4 Conclusion

The single improvement plan supported by the revised accountability framework remain the vehicle for delivery and oversight within the organisation. The criteria remain challenging to deliver within current resources and with the operational and financial pressures facing the Trust and the wider system. The Executive team and the wider organisation remain focused on the delivery of these for 2025/2026.

As the Trust has entered into the Recovery Support Programme (RSP) the Deputy Director of Improvement for the RSP has fed back recommendations from observations. Several areas were highlighted to be in need of improvement as we mature the SIP and embed across the organisation which are in progress with Executive and Senior Leaders.

3 Financial implications

Non-delivery of the plan will directly impact on the Trust's ability to deliver its waste reduction and financial improvement plan in 2025/26. Given the importance of the SIP to the Trust's recovery programme, the CEO continues to chair the monthly SIP Portfolio Board and the progress is reported monthly to the Finance and Performance committee.

4 Legal implications

None

5 Risks

5.1 Scope and oversight

The organisation has now entered National Oversight Framework (NOF) 5 the Executive team plan to review the SIP to ensure the organisation is able to drive delivery to meet requirement to exit NOF. NOF metrics have been mapped to metrics currently monitored through the SIP and will be updated to align across the NOF and SIP to ensure there is consistent oversight. There is a risk in increasing the scope of the SIP delivery plans and metrics that this is not wholly achievable within the timeframe and resource across the organisation. This may require a review of current SIP delivery plans to re-focus delivery this year.

5.2 Resource

The RSP recommendations also included implementing a robust PMO infrastructure. In May-25 there was a team restructure and consultation to create a new Programme Management Office (PMO). Substantive team members have been appointed and are expected to be in post during Q4 25/26. There is a risk to enable monitoring and delivery of the SIP if resource is not appropriately aligned. This will be partially mitigated through additional interim resource that has been allocated through an NHSE bid. This has been established during Q2 however the additional resource is currently focused on WRP delivery due to priority work required.

6 Impact on stakeholders

The impact and outcomes of delivering the improvement work is to achieve stability of the organisation in year 2 as outlined in our ambition. A number of the metrics are dependent upon collaborative working with key stakeholders and this is a key focus in 2025/26.

It is recommended that the committee:

I. Note the delivery position of the SIP for Sep-25 and key outcome metrics position.
II. Note the development of SIP maturity to embed into the organisation.

13. GOVERNANCE AND COMPLIANCE

13.1 ANNUAL MEMBERS MEETING ANALYSIS REPORT

Information Item | J Foote | 2.35pm

REFERENCES

Only PDFs are attached

13.1 - AMM analysis report - CoG Oct 2025.pdf

Council of Governors Report

Annual Members Meeting 2025 – Analysis Report							
Report to:	Council of Governors			**Date:**	30 October 2025		
Report of:	Director of Corporate Affairs			**Prepared by:**	J Foote		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☐	**For information**	☒		

Executive Summary:

In line with the requirements set out in the Constitution, the Annual Members Meeting (AMM) was held on Thursday, 25 September 2025 at Lancashire FA, The County Ground, Leyland. The event provided a platform for Governors to discharge their statutory duties in representing the interests of Trust members and the public.

The report provides an analysis of the 2025 AMM and is presented to Council 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

1. **Introduction**

In line with the requirements set out in the Constitution, the Annual Members' Meeting (AMM) was held on Thursday, 25 September 2025 from 2.00pm to 4.00pm in the Sir Tom Finney Room, The County Ground, Thurston Road, Leyland, PR25 2LF. The event provided a platform for Governors to discharge their statutory duties in representing the interests of Trust members and the public. The agenda for the AMM has been included as appendix 1 for information.

The 2025 AMM was a live face-to-face event and was recorded at the on-site venue for uploading to the Trust website. The arrangements provided choice for people on whether they attended in person or viewed the meeting at a time convenient to them. Data is provided below on attendance at the event. Arrangements are being made to upload the recording to the Trust's website, following editorial checks, which will contain the slide presentation delivered during the meeting.

Conscious of efficiencies and environmental advantages, the event was paper-lite to support the Trust's Green Plan and on arrival members were passed a limited delegate pack containing the agenda and a question card.

2. Format

The AMM was hosted by the Chair, Mike Thomas who presented an overview of achievements and performance during 2024-25, a summary of the Trust's strategy was presented by Prof Ailsa Brotherton (Chief Strategy and Improvement Officer), and a summary of the Annual Reports and Accounts was presented by Craig Carter (Interim Chief Finance Officer). The AMM also provided an opportunity for governors to explain the work undertaken over the last 12 months and how the Council, Non-Executive Directors and Board worked together in the interests of the needs of the local population. To that end, an informative presentation was delivered by Public Governor Graham Robinson. The question and answer session of the afternoon followed with responses provided by the Executive Director most closely aligned to the question posed.

The AMM received keynote speeches from Gregg Stevenson MBE (World and European Champion and Paralympic Gold Medallist), and Susan Saul (Macmillan Clinical Lead Physiotherapist – Prehabilitation) who discussed cancer prehabilitation, a multi-modal intervention aimed at optimising physical, nutritional, and psychological status to enhance treatment readiness and recovery.

The Active Lancashire team were also on site providing activities such as archery and a smoothie bike to create your own smoothies.

3. Attendance

In total 49 people attended the AMM. Disaggregating 20 attending as members of the Board, presenters, exhibitors, and support staff, this meant that 29 members of the public joined in person. Of the 29 members of the public joining in person, there were 9 Governors, 1 Staff Member, and 16 Public Members. 3 non-members also attended the event.

Category	Number
Public Members	16
Staff Members	1
Appointed Governors	9
Board of Directors[1]	8
Exhibitors[2]	6
Support[2]	6
Non-Members[3]	3
Total	**49**

[1] 4 Public and 4 Staff Members

[2] 12 Staff Members

[3] 3 members of the public

For comparison, the following table shows the breakdown of those joining the 2024 AMM:

Category	Number
Public Members	16
Staff Members	2
Appointed Governors	1
Board of Directors[1]	11
Exhibitors[2]	19
Support[2]	7
Non-Members[3]	2
Total	**58**

[1] 3 Public and 8 Staff Members

[2] 26 Staff Members

[3] 1 member of the public and 1 external person to assist with recording the AMM

4. **Publication of the Event**

The Annual Members' Meeting (AMM) 2025 was promoted through various external and internal communication channels from mid-August to late September, including a dedicated website page, digital advertisements, email invitations to members and stakeholders, social media posts, intranet graphics, weekly bulletins, leader and colleague briefings, and executive video messages to encourage attendance.

5. **Evaluation of the event**

Whilst members had been invited to register any comments regarding the event by emailing the Corporate Affairs Team, there have been no responses received to date.

Appendix 1 – 2025 Annual Members Meeting agenda

Agenda

Item	Time	Encl.	Presenter
Welcome and Introduction	2.30pm	Verbal	Prof Mike Thomas, Chair
Annual Review 2024/25	2.40pm	Presentation	Ailsa Brotherton, Chief Strategy and Improvement Officer
Annual Accounts 2024/25	2.55pm	Presentation	Craig Carter, Interim Chief Finance Officer
Council Overview - Governors	3pm	Presentation	Graham Robinson – Public Governor
Q&A Session	3.15pm	Verbal	Prof Mike Thomas, Chair
Keynote Speaker - Susan Saul on Cancer Prehab Activity	3.30pm	Presentation	Susan Saul, Macmillan Clinical Lead Physiotherapist - Prehabilitation
Keynote Speaker – Gregg Stevenson MBE	3.45pm	Presentation	Gregg Stevenson MBE, World and European Champion and Paralympic Gold Medallist
Session Close	4pm	Verbal	Prof Mike Thomas, Chair

13.2 COUNCIL OF GOVERNORS KPIS

Decision Item | J Foote | 2.45pm

REFERENCES

Only PDFs are attached

13.2 - Council of Governors KPIs - CoG 30 Oct.pdf

Council of Governors Report

2025/26 Council of Governors KPIs Proposal			
Report to:	Council of Governors	**Date:**	30 October 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	Jo Wiseman
Part I	✓	**Part II**	

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

Executive Summary:

This report presents a set of proposed key performance indicators (KPIs) for adoption by the Council of Governors for the 2025/26 year. Developed collaboratively during the training session held on 14 October 2025, these KPIs are designed to provide a clear and measurable framework for assessing the Council's effectiveness across its core areas of governance, engagement and development.
The proposed KPIs focus on six priority areas:

- Governor attendance and quoracy, with clear aspirations for participation in both subgroup and full Council meetings.
- Timely induction of new governors, ensuring all are equipped to contribute effectively.
- Retention of governors, with a review mechanism triggered by higher-than-expected resignations.
- Engagement with Non-Executive Directors, including regular observation of Board meetings and structured opportunities for feedback and accountability.
- Broader engagement, both within the Trust and with the local community, supported by an annual engagement plan and active participation in key activities.
- Ongoing training and development, with a minimum expectation for each governor to attend at least five training sessions per year.

It is recommended that the Council of Governors approve the proposed set of key performance indicators.

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

These KPIs will enable the Council to monitor its performance, identify areas for improvement, and demonstrate its commitment to effective governance and stakeholder engagement. Subject to approval at the Council of Governors meeting on 30 October 2025, these indicators will form the basis for the end of year evaluation and will also inform the Annual Report for 2025/26.

KPI Area	Indicator	Target / Threshold	Notes
Governor Attendance and Quoracy	Attendance at Subgroup meetings	75% of subgroup membership	
	Attendance at Council of Governors meetings	90% of all governors	
Governor Induction	Completion of induction for new governors	100% within two months	
Governor Retention	Number of resignations (excluding term completions)	Trigger review if more than 6 resignations (April–March)	
Engagement with Non-Executive Directors	Observe a Board of Directors meetings	At least 1 per year	
	Hybrid governor and NED meetings held at both sites	4 per year	
	Confidence survey on holding NEDs to account	Conducted now and again in April	Follow-up questions if confidence does not improve
Governor Engagement	Development of Engagement Plan	By April 2026	
	Public governor participation in engagement activities	75% to attend at least one type of activity	Includes STAR, PLACE, department visits, public events, AMM
Training	Training sessions attended	At least 5 per governor per year	

13.3 APPOINTMENT OF EXTERNAL AUDITORS

Decision Item | Audit Chair | 2.55pm

REFERENCES

Only PDFs are attached

13.3 - Appointment of External Auditors.pdf

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors

External Audit Appointment

Report to:	Council of Governors	**Date:**	30 October 2025
Report of:	Audit Chair	**Prepared by:**	Jennifer Foote

Purpose of Report

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

Executive Summary:

The Local Audit and Accountability Act 2014 ("the 2014 Act") places a legal obligation upon NHS Foundation Trusts to ensure that an External Auditor is appointed by the 31st December preceding a financial year. The National Health Service Act 2006 states that the Council of Governors must sign off the criteria for appointing.

At its meeting in November 2024, Council approved the process for an appointment to be made by 31st December 2025. This has been undertaken during 2025 with close oversight and guidance from One LSC Procurement to ensure compliance. A tender exercise under the relevant framework has been undertaken with an evaluation panel to consider the tenders received held on 23rd October. Governor representation was included as part of this. A recommendation from the evaluation panel (at the time of writing) will be made to a special meeting of the Audit Committee to be held on 27th October, with a verbal update and proposed recommendation for appointment to be given verbally at Council on 30th October.

Recommendation:
As appointing authority under the Trust constitution, Council is requested to consider the verbal recommendation of the Audit Committee and appoint as appropriate.

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

Council 7 November 2024

14. ITEMS FOR INFORMATION

14.1 GOVERNOR OPPORTUNITIES SUMMARY

Information Item

REFERENCES

Only PDFs are attached

14.1 - Governor Opportunities and Activities - July - Oct 25.pdf

Council of Governors Report

Governor Opportunities and Activities – July to October 2025

Report to:	Council of Governors	**Date:**	30 October 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	K Lawrenson
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to update the Council of Governors on the opportunities, events and activities governors have been involved in during July to October 2025.

The governor role is to represent the interests of Foundation Trust members, the public and the organisations the appointed governors represent. The events and engagement opportunities that Governors have been involved in are recorded in the report and attached as appendix 1.

It should also be noted that several governors also undertake voluntary roles across both our hospital sites.

It is recommended that the Council of Governors receive the report and note the contents for information.

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

There are a number of regular activities which Governors could be involved in including:

STAR celebration events
Held three times per year, teams present the peer support activity in which they have been involved as part of the STAR accreditation framework as well as celebrating achievements.

PLACE (Patient Led Assessment of the Care Environment)
The national programme usually takes place annually at each of our hospital sites (Chorley and South Ribble and Royal Preston Hospital). It is an opportunity for Governors to engage with patients and training is provided by the Trust.

The list below does not include scheduled meetings of Council and workshops.

EVENT: excluding scheduled meetings and workshops	**DATE: 2 July to 30 October 2025**
Patient and Carers Experience and Involvement Group (P&CEIG)	28 July 2025
Board of Directors Public Meeting	7 August 2025
Council Training Session – Council Effectiveness Review	8 August 2025
Patient and Carers Experience and Involvement Group (P&CEIG)	26 August 2025
Carer's Forum	27 August 2025
Joint Board and Governor Development – Trust Strategy	23 September 2025
Carer's Forum	24 September 2025
Annual Members Meeting	25 September 2025
Patient and Carers Experience and Involvement Group (P&CEIG)	30 September 2025
PLACE Audit	30 September 2025
Board of Directors Public Meeting	2 October 2025
PLACE Audit	9 October 2025
Council of Governors KPI Setting Meeting	14 October 2025
Catering Visit	24 October 2025
Patient and Carers Experience and Involvement Group (P&CEIG)	28 October 2025
Carer's Forum	29 October 2025

14.2 GOVERNOR ISSUES REPORT

Information Item

REFERENCES

Only PDFs are attached

14.2 - Governor Issues Report - CoG 30 Oct.pdf

Council of Governors Report

Governor Issues Report			
Report to:	Council of Governors	**Date:**	30 October 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	K Lawrenson, Corporate Affairs Officer
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide visibility of the issues and concerns raised by Governors for information.

The agreed process for Governors to raise issues and concerns is through the Corporate Affairs Team (CorporateAffairs@lthtr.nhs.uk). These are then passed to the appropriate manager for investigation and response. A response is then provided to the Governor who raised the issue, with a summary submitted to Council as part of this report.

During the period August to October 2025 two issues were raised.

The first issue concerned staff and patient security risks due to the lack of security cameras at Chorley Hospital. The response, sent on 8 August 2025, confirmed that a scheme had been approved to install a new CCTV system at Chorley District Hospital, with work scheduled to begin in the next couple of months and completion expected by March 2026.

The second issue regarded discarded items around Chorley Hospital that needed to be removed. The estates team addressed the issue, and by 12 August 2025, all items had been removed. Additionally, a bin containing used cooking oil was requested to be removed by the appropriate team.

It is recommended that the Council 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

Not applicable

14.3 CORPORATE AND GOVERNOR CALENDAR

Information Item

REFERENCES

Only PDFs are attached

14.3 - Corporate and Governor Calendar 2026-27 - V2 August 2025 .pdf

Please do not print!

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Corporate and Governors' Calendar 2026-27

This calendar contains the dates of all meetings for the following:

BOARD OF DIRECTORS AND COMMITTEES OF THE BOARD:

- Appointments, Remuneration and Terms of Employment (ARTE) Committee
- Audit Committee
- Board of Directors
- Board Workshops
- Charitable Funds Committee
- Education, Training and Research Committee
- Finance and Performance Committee
- Non-Executive Directors' meetings
- Safety and Quality Committee
- Workforce Committee
- Board Strategy Away Day

COUNCIL OF GOVERNORS, SUBGROUPS, AND MISCELLANEOUS MEETINGS:

- Care and Safety Subgroup
- Chairs, Deputy Chairs and Lead Governor
- Council Training Sessions
- Council of Governors
- Membership Subgroup
- Nominations Committee
- Joint Board and Council Development Sessions
- Annual Members' Meeting

If you have any queries, please contact Corporate Affairs by email:
company.secretary@lthtr.nhs.uk

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2026-27 Overview *(The venues in the Calendar will be kept under constant review and a revised version published on the Trust's website on a regular basis)*

APRIL 2026		
02	9.15am – 3.00pm	Board of Directors
07	10.00am – 11.00am	Chairs, Deputy Chairs and Lead Governor
07	1.00pm – 3.00pm	Education, Training and Research Committee
09	11.00am – 12.30pm	Nominations Committee
16	10.30am – 1.00pm	Audit Committee
23	1.00pm – 4.00pm	Council of Governors
24	11.00am – 1.30pm	Safety and Quality Committee
28	1.00pm – 4.00pm	Finance and Performance Committee
30	2.00pm – 3.30pm	Appointments, Remuneration and Terms of Employment (ARTE) Committee

MAY 2026		
05	10.00am – 12.30pm	Board Workshop
11	10.00am – 12.30pm	Care and Safety Subgroup
12	10.00am – 11.30am	Membership Subgroup
12	1.00pm – 3.00pm	Workforce Committee
14	1.00pm – 3.00pm	Council Training Session
21	1.00pm – 3.00pm	Joint Board and Governor Development Session
26	1.00pm – 4.00pm	Finance and Performance Committee
29	11.00am – 1.30pm	Safety and Quality Committee

JUNE 2026		
04	9.15am – 3.00pm	Board of Directors
16	1.00pm – 2.30pm	Charitable Funds Committee
18	9.30am – 11.30am	Audit Committee
23	1.00pm – 4.00pm	Finance and Performance Committee
26	11.00am – 1.30pm	Safety and Quality Committee

JULY 2026		
08	11.30am – 12.30pm	Chairs, Deputy Chairs and Lead Governor
14	1.00pm – 3.00pm	Workforce Committee
16	12.30pm – 3.00pm	Care and Safety Subgroup
23	10.00am – 1.00pm	Council of Governors
28	1.00pm – 4.00pm	Finance and Performance Committee
30	1.00pm – 3.30pm	Board Workshop
31	11.00am – 1.30pm	Safety and Quality Committee

AUGUST 2026		
06	9.15am – 3.00pm	Board of Directors
11	1.00pm – 3.00pm	Education, Training and Research Committee
14	10.00am – 11.30am	Membership Subgroup
20	1.00pm – 3.00pm	Council Training Session
25	1.00pm – 4.00pm	Finance and Performance Committee
27	11.00am – 12.30pm	Appointments, Remuneration and Terms of Employment (ARTE) Committee
28	11.00am – 1.30pm	Safety and Quality Committee

SEPTEMBER 2026		
01	10.00am – 12.30pm	Board Workshop
08	1.00pm – 3.00pm	Workforce Committee
09	10.00am – 12.30pm	Care and Safety Subgroup
10	11.00am – 12.30pm	Appointments, Remuneration and Terms of Employment (ARTE) Committee
15	1.00pm – 2.30pm	Charitable Funds Committee
17	10.30am – 1.00pm	Audit Committee
22	1.00pm – 4.00pm	Finance and Performance Committee
24	1.00pm – 3.00pm	Joint Board and Council Development Session
25	11.00am – 1.30pm	Safety and Quality Committee

OCTOBER 2026		
01	9.15am – 3.00pm	Board of Directors
06	10.00am – 11.00am	Chairs, Deputy Chairs and Lead Governor
08	2.00pm – 4.00pm	Annual Members' Meeting
13	1.00pm – 3.00pm	Education, Training and Research Committee
15	10.00am – 12.00pm	Council Training Session
22	1.00pm – 4.00pm	Council of Governors
27	1.00pm – 4.00pm	Finance and Performance Committee
30	11.00am – 1.30pm	Safety and Quality Committee

NOVEMBER 2026		
03	1.00pm – 3.30pm	Board Workshop
09	12.30pm – 3.00pm	Care and Safety Subgroup
10	1.00pm – 3.00pm	Workforce Committee
17	2.00pm – 3.30pm	Membership Subgroup
24	1.00pm – 4.00pm	Finance and Performance Committee
27	11.00am – 1.30pm	Safety and Quality Committee

DECEMBER 2026		
03	9.15am – 3.00pm	Board of Directors
15	1.00pm – 2.30pm	Charitable Funds Committee
17	1.00pm – 3.00pm	Council Training Session
22	1.00pm – 4.00pm	Finance and Performance Committee

JANUARY 2027		
05	10.00am – 11.00am	Chairs, Deputy Chairs and Lead Governor
05	1.00pm – 3.00pm	Education, Training and Research Committee
08	11.00am – 1.30pm	Safety and Quality Committee
12	1.00pm – 3.00pm	Workforce Committee
14	10.30am – 1.00pm	Audit Committee
18	10.00am – 12.30pm	Care and Safety Subgroup
20	10.00am – 12.30pm	Board Workshop
21	1.00pm – 4.00pm	Council of Governors
26	1.00pm – 4.00pm	Finance and Performance Committee
29	11.00am – 1.30pm	Safety and Quality Committee

FEBRUARY 2027		
04	9.15am – 3.00pm	Board of Directors
11	10.00am – 12.00pm	Council Training Session
12	10.00am – 11.30am	Membership Subgroup
23	1.00pm – 4.00pm	Finance and Performance Committee
26	11.00am – 1.30pm	Safety and Quality Committee

MARCH 2027		
02	1.00pm – 3.30pm	Board Workshop
04	12.30pm – 3.00pm	Care and Safety Subgroup
09	1.00pm – 3.00pm	Workforce Committee
16	1.00pm – 2.30pm	Charitable Funds Committee
23	1.00pm – 4.00pm	Finance and Performance Committee
26	11.00am – 1.30pm	Safety and Quality Committee

Appointments, Remuneration and Terms of Employment (ARTE) Committee

Date	Time	Venue	Final date for receipt of reports:
30/04/2026	2.00pm – 3.30pm	Virtually using Microsoft Teams	23/04/2026
10/09/2026	11.00am – 12.30pm	Virtually using Microsoft Teams	03/09/2026

Members	In attendance
Chair Non-Executive Directors	Chief Executive Officer Chief People Officer Director of Corporate Affairs Associate Company Secretary (minutes)

Audit Committee

Date	Time	Venue	Final date for receipt of reports:
16/04/2026	10.30am – 1.00pm	Virtually using Microsoft Teams	09/04/2026
18/06/2026	9.30am – 11.30am	Virtually using Microsoft Teams	11/06/2026
17/09/2026	10.30am – 1.00pm	Virtually using Microsoft Teams	10/09/2026
14/01/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	07/01/2027

Members	In attendance
Four Non-Executive Directors: - Audit Committee Chair - Finance and Performance Committee Chair - Safety and Quality Committee Chair - Workforce Committee Chair	Chief Executive Officer (as required) Chief Finance Officer Internal and External Audit representatives Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Board of Directors

Date	Time	Venue	Final date for receipt of reports:
02/04/2026	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/03/2026
04/06/2026	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	28/05/2026
06/08/2026	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	31/07/2026
01/10/2026	9.15am – 3.00pm	Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital	24/09/2026
03/12/2026	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/11/2026
04/02/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/01/2027

Members	In attendance
Chair Non-Executive Directors Chief Officers	Chief People Officer Director of Continuous Improvement and Research Director of Communications and Engagement Director of Corporate Affairs Associate Company Secretary (minutes)

Board Strategy Away Day

Date	Time	Venue	Final date for receipt of reports:
		To Be Confirmed	

Attendees
Chair Non-Executive Directors Chief Officers Chief People Officer Director of Continuous Improvement and Research Director of Communications and Engagement Director of Corporate Affairs

Board Workshop

Date	Time	Venue	Final date for receipt of reports:
05/05/2026	10.00am – 12.30pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	28/04/2026
30/07/2026	1.00pm – 3.30pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	23/07/2026
01/09/2026	10.00am – 12.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	25/08/2026
03/11/2026	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	27/10/2026
20/01/2027	10.00am – 12.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	13/01/2027
02/03/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	23/02/2027

Members	In attendance
Chair Non-Executive Directors Chief Officers	Chief People Officer Director of Continuous Improvement and Research Director of Communications and Engagement Director of Corporate Affairs Corporate Affairs Officer (notes and actions)

Charitable Funds Committee

Date	Time	Venue	Final date for receipt of reports:
16/06/2026	1.00pm - 2.30pm	Virtually using Microsoft Teams	09/06/2026
15/09/2026	1.00pm - 2.30pm	Virtually using Microsoft Teams	08/09/2026
15/12/2026	1.00pm - 2.30pm	Virtually using Microsoft Teams	08/12/2026
16/03/2027	1.00pm - 2.30pm	Virtually using Microsoft Teams	09/03/2027

Members	In attendance
Three Non-Executive Directors comprising: - Committee Chair - Two Non-Executive Directors Chief Nursing Officer	Head of Charities Director of Communications and Engagement Director of Corporate Affairs Corporate Affairs Officer (minutes)

Education, Training and Research Committee

Date	Time	Venue	Final date for receipt of reports:
07/04/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	31/03/2026
11/08/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	04/08/2026
13/10/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	06/10/2026
05/01/2027	1.00pm - 3.00pm	Virtually using Microsoft Teams	30/12/2026

Members	In attendance
Three Non-Executive Directors comprising: - Committee Chair - Two Non-Executive Directors Chief People Officer Chief Medical Officer	Director of Research *(or in his absence the Deputy Director of Research and Innovation)* Deputy Chief Nursing Officer Dean of Undergraduate Medical Education Director of Postgraduate Medical Education Deputy Director of Education Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Finance and Performance Committee

Date	Time	Venue	Final date for receipt of reports:
28/04/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	21/04/2026
26/05/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	19/05/2026
23/06/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	16/06/2026
28/07/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	21/07/2026
25/08/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	18/08/2026
22/09/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	15/09/2026
27/10/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	20/10/2026
24/11/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	17/11/2026
22/12/2026	1.00pm - 4.00pm	Virtually using Microsoft Teams	15/12/2026
26/01/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	19/01/2027
23/02/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	16/02/2027
23/03/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	16/03/2027

Members	In attendance
Three Non-Executive Directors comprising: - Committee Chair - Two Non-Executive Directors Chief Operating Officer Chief Finance Officer	Chief Medical Officer Chief People Officer Director of Continuous Improvement and Research Deputy Chief Nursing Officer Deputy Medical Director for Professional Standards Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Non-Executive Directors' meetings

Date	Time	Venue

The Non-Executive Directors are scheduled to meet informally on a monthly basis and will review the frequency as required.

Members	In attendance
Chair Non-Executive Directors	Chief Executive Officer or Deputy Chief Executive Officer (as required) Director of Corporate Affairs

Safety and Quality Committee

Date	Time	Venue	Final date for receipt of reports:
24/04/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	17/04/2026
29/05/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	22/05/2026
26/06/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	19/06/2026
31/07/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	24/07/2026
28/08/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	21/08/2026
25/09/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	18/09/2026
30/10/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	23/10/2026
27/11/2026	11.00am – 1.30pm	Virtually using Microsoft Teams	20/11/2026
08/01/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	01/01/2027
29/01/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	22/01/2027
26/02/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	19/02/2027
26/03/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	19/03/2027

Members	In attendance
Three Non-Executive Directors comprising: - Committee Chair - Two Non-Executive Directors Chief Operating Officer Chief Medical Officer Chief Nursing Officer	Deputy Chief Medical Officer for Governance Associate Director of Safety and Learning Associate Director of Risk and Assurance Senior Associate Director of Continuous Improvement and Research Deputy Chief Nursing Officer Director of Corporate Affairs Corporate Affairs Officer (minutes)

Workforce Committee

Date	Time	Venue	Final date for receipt of reports:
12/05/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	07/05/2026
14/07/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	07/07/2026
08/09/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	01/09/2026
10/11/2026	1.00pm - 3.00pm	Virtually using Microsoft Teams	03/11/2026
12/01/2027	1.00pm - 3.00pm	Virtually using Microsoft Teams	05/01/2027
09/03/2027	1.00pm - 3.00pm	Virtually using Microsoft Teams	02/03/2027

Members	In attendance
Three Non-Executive Directors comprising: - Committee Chair - Two Non-Executive Directors Chief Nursing Officer	Chief People Officer Director of Communications and Engagement Deputy Medical Director for Professional Standards Deputy Chief Operating Officer Deputy Director of Workforce and Organisational Development Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Care and Safety Subgroup

Date	Time	Venue	Final date for receipt of reports:
11/05/2026	10.00am - 12.30pm	TBC	05/05/2026
16/07/2026	12.30pm - 3:00pm	TBC	03/07/2026
09/09/2026	10.00am - 12.30pm	TBC	08/09/2026
09/11/2026	12.30pm - 3:00pm	TBC	06/11/2026
18/01/2027	10.00am - 12.30pm	TBC	05/01/2027
04/03/2027	12.30pm - 3:00pm	TBC	12/03/2027

Members	In attendance
Governors	Non-Executive Director (Safety and Quality Committee Chair) Director of Facilities and Services Associate Director of Patient Quality, Experience and Engagement Patient Experience Lead Director of Corporate Affairs Corporate Affairs Officer (minutes)

Chairs, Deputy Chairs and Lead Governor

Date	Time	Venue	Final date for receipt of reports:
07/04/2026	10.00am – 11.00am	Virtually using Microsoft Teams	31/03/2026
08/07/2026	11.30am – 12.30pm	Virtually using Microsoft Teams	01/07/2026
06/10/2026	10.00am – 11.00am	Virtually using Microsoft Teams	30/09/2026
05/01/2027	10.00am – 11.00am	Virtually using Microsoft Teams	30/12/2026

Members	In attendance
Chairs and Deputy Chairs of Council Subgroups Lead Governor Chair Chief Executive Officer	Director of Corporate Affairs Corporate Affairs Officer (minutes)

Council Training Sessions

Date	Time	Venue	Final date for receipt of reports:
14/05/2026	1.00pm - 3.00pm	Seminar Room 5, Education Centre 1, Royal Preston Hospital	07/05/2026
20/08/2026	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	13/08/2026
15/10/2026	10.00am - 12.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	08/10/2026
17/12/2026	1.00pm - 3.00pm	Seminar Room A1, Education Centre 3, Chorley & South Ribble Hospital	10/12/2026
11/02/2027	10.00am-12.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	04/02/2027

Members	In attendance
Chair Governors	Executive Directors – *to be confirmed* Director of Corporate Affairs Corporate Affairs Officer (notes and actions)

Council of Governors

Date	Time	Venue	Final date for receipt of reports:
23/04/2026	1:00pm - 4:00pm	Seminar Room A, Education Centre 3, Chorley & South Ribble Hospital	16/04/2026
23/07/2026	10.00am - 1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	16/07/2026
22/10/2026	1:00pm - 4:00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	15/10/2026
21/01/2027	1.00pm - 4.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	14/01/2027

Members	In attendance
Chair Governors	Chief Executive Officer Non-Executive Directors Director of Corporate Affairs Associate Company Secretary (minutes)

Membership Subgroup

Date	Time	Venue	Final date for receipt of reports:
12/05/2026	10.00am – 11.30am	TBC	05/05/2026
14/08/2026	10.00am – 11.30am	TBC	07/08/2026
17/11/2026	2.00pm – 3.30pm	TBC	10/11/2026
12/02/2027	10.00am – 11.30am	TBC	05/02/2027

Members	In attendance
Governors	Widening Partnership Manager Director of Corporate Affairs Corporate Affairs Officer (minutes)

Nominations Committee

Date	Time	Venue	Final date for receipt of reports:
09/04/2026	11:00am - 12:30pm	Virtually using Microsoft Teams	02/04/2026

Members	In attendance
Chair One Staff Governor *(or Substitute)* Two Public Governors *(or Substitute)* One Appointed Governor *(or Substitute)*	Chief Executive Officer Chief People Officer Director of Corporate Affairs Corporate Affairs Officer (minutes)

Joint Board and Council Development Session

Date	Time	Venue	Final date for receipt of reports:
21/05/2026	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	14/05/2026
24/09/2026	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	17/09/2026

Members	In attendance
Chair Non-Executive Directors Chief Officers Director of Continuous Improvement and Research Director of Communications and Engagement Governors	Director of Corporate Affairs Corporate Affairs Officer (notes and actions)

Annual Members' Meeting

Date	Time	Venue
08/10/2026	2.00pm – 4.00pm	To be confirmed

Members	In attendance
Chair Non-Executive Directors Chief Officers Director of Continuous Improvement and Research Director of Communications and Engagement *All other staff welcome to attend*	Communications Team Director of Corporate Affairs Associate Company Secretary Corporate Affairs Officers

14.4 MINUTES OF GOVERNOR SUBGROUPS

(a) Care and Safety Subgroup ? 10 July 2025
(b) Membership Subgroup ?5 August 2025
(c) Chairs, Deputy Chairs and Lead Governor ? 15 October 2025

REFERENCES

Only PDFs are attached

14.4a - Minutes CaSS Subgroup 10 July 2025.pdf

14.4b - Minutes - Membership Subgroup - 5 August 2025 approved.pdf

14.4c - Minutes - Chairs Deputy Chairs and Lead Governor - 15 October 2025 - Approved.pdf

Care and Safety Subgroup

10 July 2025 | 12.30pm | Microsoft Teams

Members:

Janet Miller	Public Governor (Chair)
George Bailey	Public Governor
Margaret France	Public Governor
Graham Fullarton	Public Governor
Lou Jackson	Appointed Governor
Angela Kos	Public Governor
Carole Oldcorn	Public Governor
Christine Pownall	Public Governor
Frank Robinson	Public Governor
Graham Robinson	Public Governor (Vice Chair)
Apologies:	T Young and P Brooks

In Attendance:

John Howles	Associate Director of Patient Experience & Engagement
Karen Lawrenson	Coporate Affairs Officer
Alison McCrudden	Patient Experience and Involvement Lead
Apologies:	Dr K Deeny

34/25 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.

35/25 Declarations of interest

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

36/25 Minutes of the previous meeting

The minutes of the meeting held on 12 May 2025 were approved as an accurate record.

37/25 Matters arising and action log

The action log was reviewed and updated.

Attention was drawn to the Blue Badge scheme and the upgraded parking software. It was noted that a document had been uploaded to the website, but concerns were raised regarding its accessibility. The font size was considered too small for users with visual impairments and the format was described as not user-friendly. It was clarified that the document in question was a “how to” guide for scanning Blue Badges at kiosks, presented in a flipbook-style format. While the document allowed for full-screen viewing and zooming, it was agreed that users might not be aware of these features.

It was suggested that additional instructions be added to the website to guide users on how to enlarge the text. It was agreed to liaise with the communications team to improve the guidance provided alongside the document.

38/25 Estates and Facilities Update

Due to unforeseen operational pressures, no representative was available.

39/25 Patient Quality, Experience and Engagement Update

The Associate Director of Patient Experience & Engagement provided an overview. It was confirmed that eight beds on Ward 12 had been closed to facilitate the expansion of the Surgical Assessment Unit (SAU) on Ward 3. This transformation involved relocating services, including the DOSA unit, to a new facility near radiotherapy. Ward 4 had also been repositioned as part of this reconfiguration. The changes were described as transitional, with ongoing efforts to enhance the space, including the creation of a relatives' room.

In terms of patient experience, twelve key priorities had been agreed within the Single Improvement Plan. These included addressing health inequalities, enhancing volunteer involvement and improving data metric particularly qualitative feedback from the Friends and Family Test. Progress had been made in capturing demographic data and in tailoring feedback methods for individuals with mental health needs, learning disabilities, or those requiring carer support. A report would be produced to reflect this multi-faceted approach.

Collaborative work was ongoing with external partners, including a recent discussion with a French colleague regarding the use of Friends and Family data. Community engagement had also been strengthened, with local input influencing policies such as intentional rounding and enhanced therapeutic observations. Plans were in place to reinvigorate the patient champion programme and to develop a single operational policy for collecting patient experience data, ensuring consistency across all roles.

Concerns were raised regarding communication around the closure of beds on Ward 12. It was clarified that no bed capacity had been lost and updates had been shared through Trust communications and weekly team meetings. However, it was acknowledged that boarding remained an issue across some wards.

A key risk identified was the cancellation of outpatient appointments, particularly those generated erroneously through the ERS system or booked into non-existent clinics. These issues were being addressed through a rapid improvement process and feedback was being sought to inform further action. Communication challenges were noted and efforts were underway to improve messaging and transparency around these system failures. The importance of qualitative feedback and the need for a consolidated communication was noted.

The Associate Director of Patient Experience & Engagement then left the meeting.

40/25 Patient Experience and Involvement Update

The Patient Experience and Involvement Lead provided an overview of the report. The Patient Information Group had reviewed leaflets in May and June to ensure clarity and accessibility for patients. A link to the research department was added to all patient information templates to support recruitment efforts for research participation.

The Carers Forum, co-chaired with a representative from Lancashire Carers, continued to meet regularly. A recent session included a presentation from the lead for resource, which prompted valuable discussion among forum members.

Awareness of Age UK Lancashire's presence at Chorley Hospital was raised. Although the office was not accessible to patients, a poster had been developed to inform staff and patients of the services available, including a contact number for arranging meetings on hospital grounds.

Engagement with lesser-heard communities had increased. The Deaf community in Preston was consulted, resulting in video interviews capturing both positive and challenging experiences. Concerns had been raised about communication barriers, particularly the lack of interpreters and reliance on written notes. The need for mandatory deaf awareness training was highlighted, especially for new staff and students.

Further engagement took place with the Asian Ladies Forum in Chorley, where language and digital barriers were identified as reasons for low participation in feedback surveys. Attendees expressed reluctance to provide negative feedback due to concerns about treatment. However, video interpretation services were praised for improving understanding and communication during maternity care.

The Visual Impairment Forum collaborated with the Pukar Disability Centre, and a joint event was held with representatives from various health and social care organisations. Additional outreach included a visit to the Muslim Education Centre, where older women shared experiences of long waits in A&E, lack of privacy and difficulties with food menus due to language barriers. The use of iPads for meal ordering and interpretation services was discussed. While some wards had sufficient devices, issues such as uncharged equipment and underuse were noted. The idea of including photographs of meals on digital menus was suggested as a way to improve accessibility.

Concerns had been raised about the future of Healthwatch and other public engagement groups, with indications that they may be disbanded by late 2026. The involvement team remained active in task and finish groups, particularly those focused on British Sign Language (BSL) forums. The discussion also addressed digital exclusion. It was noted that many patients, particularly older individuals, struggle with digital platforms. Suggestions included community-led digital training and improved awareness of existing support services. The importance of maintaining non-digital options was emphasised to ensure inclusivity. It was advised that the South Ribble Council offered social prescribing services that offered support with technology and paperwork.

41/25 Non-Executive Director Update

No update available.

42/25 Reflections on the meeting and recent visits to Pharmacy and the DOSA Unit

Reflections were shared on recent visits to the Pharmacy department and the new DOSA unit. Attendees found the pharmacy visit particularly enlightening, with several noting how it expanded their understanding of the complexity behind medication distribution. The use of advanced technology, including robotic systems with dual barcode scanning, was highlighted as a key feature. The department was described as operating like a standalone business unit, supplying medicines across hospitals and GP practices. The

procurement process was discussed, including a reported annual budget of £70 million and £3 million worth of stock held on-site.

The DOSA unit visit was praised for its modern, clean and well-designed environment, which was seen as a significant improvement over other areas of the hospital. Attendees expressed interest in revisiting the unit in six months to observe its operation with patients in place. Concerns were raised about specific design elements, including the absence of red grab rails and toilet seats, which are recommended for dementia-friendly facilities. Issues with the flooring and external signage had been noted, with calls for greater attention to detail in final finishes.

The discussion broadened to reflect on the challenge of embedding good initiatives within the Trust. Examples such as dementia-friendly design, red plates and blue trays, and the PJ Paralysis campaign were cited as efforts that had faded over time. It was suggested that these initiatives often lacked continuity and ownership, leading to their gradual disappearance despite initial success. The importance of incorporating such practices into mandatory training and ensuring they are sustained across staff changes was emphasised. It was suggested that these topics could be revisited within the Patient Experience Group to explore how successful initiatives could be better maintained and embedded into everyday practice.

43/25 Request for future meeting topics and any other business

Future visits: Suggestions for future visits included the Medical Assessment Unit at Chorley, particularly following recent layout changes. In six months, a return to the newly renamed Lancashire Elective Surgery Hub (formerly DOSA).

Future meeting topics: The discussion acknowledged the pressures faced by the communications team, including staffing shortages, but reiterated the importance of maintaining high standards in patient communications. It was noted that while the Trust had received recognition for accessibility, there remained room for improvement in usability and content management.

Concerns were raised again about the readability of certain documents on the Trust's website, particularly those related to parking guidance. It was suggested that clearer instructions should be included directly on the page, rather than relying on users to expand or navigate embedded documents. The need for up-to-date and relevant information on the website's homepage was also emphasised, with criticism directed at outdated or non-essential content being prioritised over practical updates.

A separate point was raised regarding the NHS 10-Year Plan and its potential impact on hospital operations and finances. It was suggested that a joint meeting with Non-Executive Directors be arranged to discuss the implications in more detail.

As the Membership Subgroup had moved to a face to face meeting it was suggested that Care and Safety Subgroup consider the format of the next meeting, scheduled for 15 September. There was a general preference for a face-to-face meeting, with agreement that a hybrid option should be made available to accommodate those unable to attend in person.

Date, time, and venue of next meeting

15 September 2025 at 10.00am using Microsoft Teams.

Membership Subgroup

5 August 2025 | 2.00pm | Hybrid Meeting, Gordon Hesling Conference Room, RPH

Members:

Sheila Brennan	Chair
George Bailey	Deputy Chair
Janet Miller	Public Governor
Enid Povey	Public Governor (via MS Teams)
Graham Robinson	Public Governor
Tim Young	Public Governor (via MS Teams)

Apologies:

Frank Robinson	Public Governor

In attendance:

Karen Lawrenson	Corporate Affairs Officer (via MS Teams, minutes)

9/25 Chair and quorum

The Chair noted that due notice of the meeting had been given to each member and a quorum was present.

10/25 Declaration of interests

There were no declarations made in respect of the business to be transacted during the meeting.

11/25 Minutes of the previous meeting held on 5 June 2025

The minutes were accepted as a true and accurate record. It was noted that the time of the meeting should reflect the correct start time.

12/25 Matters arising and action log

The action log would be updated accordingly.

With reference to minute 7/25, the social media policy was referred to which did not specifically state who could and could not hold a social media account for the Trust. It was confirmed that any department/group wishing to establish a social media presence was required to seek permission from the communications team, who would assign the account title. Responsibility for content rested with the designated post holders, and the communications team were to be granted access to account passwords in order to monitor activity. While there was no explicit prohibition on account ownership, the communications team retained final authority over approval. A review conducted in 2022 revealed a discrepancy between the number of known and unknown accounts, with significantly more accounts existing than were recorded by communications. Request was

made for clarification on why governors holding an account would be against social media policy, the Chair would communicate with the Director of Corporate Affairs in this regard. Suggestion was made that the subgroup themselves should submit an application for an account as per the policy. A copy of the social media policy referred to in the meeting would be circulated to members of the subgroup by the Chair of the Committee.

13/25 Membership Publicity

Lack of membership publicity on hospital premises and the need to promote the annual members meeting was discussed. Suggestion was made for using banners, posters, and social media channels to increase awareness of membership and annual members meeting. A request was made for a brief meeting with the Director of Communications and the Communications Team to be arranged to discuss planned publicity for the annual members meeting, or alternatively Communications Team to provide further information within the next week.

14/25 Events Diary

No forthcoming events which the Governors could attend were noted. A query was raised around the membership secretary post which had recently been advertised with action taken to provide clarity on the position of that role.

15/25 Key Performance Indicators for Membership Subgroup 2025-2026

The introduction of KPIs for the membership subgroup was noted. It was agreed to discuss this further at the upcoming training session to understand the rationale behind the KPIs and would be discussed further at the next subgroup meeting.

A discussion took place on issues surrounding the membership system managed via Civica. It was noted that individuals had experienced difficulties registering and receiving communications despite multiple attempts. Concerns were raised about the accuracy and timeliness of data input into Civica, particularly regarding deceased members and outdated records. The group noted the need for better communication with Civica to ensure accurate records.

Members of the subgroup agreed to hold an informal meeting in four weeks' time to discuss the annual members meeting.

Date, time, and venue of next meeting:

3 October 2025, 10am, hybrid meeting, Gordon Hesling Conference Room, RPH

The meeting concluded at 2.45pm

Chairs, Deputy Chairs and Lead Governor with the Chair and Chief Executive

15 October 2025 | 11.00am | Microsoft Teams

PRESENT

Prof. Mike Thomas	Chair
Janet Miller	Lead Governor
Graham Robinson	Public Governor, Deputy Care and Safety Subgroup
George Bailey	Public Governor, Deputy Membership Subgroup
Apologies:	Silas Nicholls, Sheila Brennan

IN ATTENDANCE

Jennifer Foote	Director of Corporate Affairs
Jo Wiseman	Interim Business Manager, Corporate Affairs (minutes)

15/25 Minutes of the previous meeting

The minutes of the meeting held on 1 July 2025 were agreed as a true and accurate record.

16/25 Matters arising and action log

The action log was reviewed and would be updated accordingly. The ongoing action regarding the linkage of Councils from foundation trusts as part of the system-wide pathway remained in progress. The action for the Care and Safety Subgroup to review its terms of reference had been closed. The Membership Subgroup had not met to discuss its terms of reference.

17/25 Chair and Chief Executive update on key issues

An update was provided on the Trust's position in special measures, with finances showing traction however ongoing pressures were anticipated due to winter demand and an increase in respiratory illnesses. The Trust had submitted bids for innovation funding, including support for a surgical hub within the system and digital improvements to waiting list management. Performance remained under scrutiny, with statutory obligations to report to national bodies. Progress was noted in reducing long waiting lists, though this had led to an increase in mid-range waits. The recovery support team had expressed satisfaction with progress and further updates were expected. The Trust awaited confirmation of additional funding for A&E services at CDH. The Section 111 letter was due to be refreshed, outlining statutory requirements for the next phase of recovery. Staffing and resource challenges were acknowledged, particularly in relation to winter pressures and service delivery.

18/25 Draft Council of Governors agendas – 30 October 2025

The draft agenda for the Council of Governors meeting was discussed with the latest version reflecting updates on KPIs and the appointment of external audit. It was agreed that the Care and Safety Subgroup's terms of reference would be included once they had been reviewed by the Director of Corporate Affairs to ensure they remained compliant.

19/25 Subgroups and Lead Governor updates

(a) ***Care and Safety Subgroup*** *(Janet Miller)*

There had been a meeting on 10 July and 15 September 2025 for Care and Safety Subgroup. Key priorities included addressing health inequalities, enhancing volunteer involvement and improving feedback mechanisms. Efforts were underway to improve communication with patients and to support those living with dementia. Recruitment for new patient safety partners continued and several purchases had been approved by the Patient Experience Fund. Concerns were raised regarding staff eligibility for Covid vaccinations and the availability of cleaning supplies for IT equipment. Governors were invited to attend a Sepsis Conference and undertook visits to various Trust facilities. The subgroup updated its terms of reference for approval at the next council meeting.

(b) ***Membership Subgroup*** *(George Bailey)*

The Membership Subgroup had not yet met to update its terms of reference. Efforts were focused on promoting membership, increasing diversity and still exploring the use of social media to support engagement. The subgroup aimed to improve attendance and participation with KPIs developed to monitor progress.

(c) ***Lead Governor update*** *(Janet Miller)*

The Lead Governor attended a range of meetings and forums, including patient and carer experience groups, staff ambassador forums and dementia strategy meetings. Participation in audits and KPI-setting sessions was noted, with governor training highlighted as an area for improvement.

20/25 Other Items

(a) **AMM – Outcome and Attendance**

The Annual Members Meeting had been attended by nineteen members of the public, an increase on the previous year. The event was considered successful, though suggestions were made for further improvement, including increasing attendance and exploring alternative venues although the venue had been an excellent location with ample car parking. The importance of communicating the Trust's financial position and challenges was emphasised as it had been well presented.

(b) **Contributions to the Council Agenda**

It was noted that governors wanted to have the opportunity to contribute items to the Council agenda prior to meetings. It was explained that all governors were able to share topics at any time and that Corporate Affairs maintained a list of matters of interest to be covered either by reports or workshops. It was agreed that any requests received would be shared prior to future meetings.

(c) **Governor Support Role**

An update was provided regarding the governor administration support role that had been advertised more recently. Assurance was given that recruitment was progressing, with interviews scheduled. The Band 7 Corporate Affairs post was a replacement for a long-serving staff member who had retired due to ill health.

(d) **GGI Report Availability**

The update on the GGI report informed that a board workshop had been held to develop an action plan in response to its recommendations, and the final version was expected to be shared at the December Board meeting, when it would be made public.

Date, time and venue of next meeting

The Chair advised that the next meeting was scheduled for 16 December 2025 at 3.00pm via Microsoft Teams.

Meeting closed at 11.54am

14.5 DATE, TIME AND VENUE OF NEXT MEETING: 20 JANUARY 2026, 1.00PM, LECTURE ROOM 1, EDUCATION CENTRE 1, ROYAL PRESTON HOSPITAL

Information Item | M Thomas | 2.59pm

15. REVIEW OF MEETING PERFORMANCE

15.1 DISCUSSION ON HOW THE MEETING IN PUBLIC HAS BEEN CONDUCTED

Information Item | All | 3.00pm

Verbal

16. RESOLUTION TO REMOVE PRESS AND PUBLIC

16.1 RESOLUTION TO EXCLUDE MEMBERS OF THE PRESS AND PUBLIC

Information Item | M Thomas | 3.00pm

Verbal