



Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I ANCILLARY PACK



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1 October 2026



09:30 GMT+1 Europe/London



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



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8.0 BOARD ASSURANCE FRAMEWORK

● Decision Item

REFERENCES

Only PDFs are attached



8.0 Board Assurance Framework Ancillary Board Pt I October 2026.pdf

1. Background

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

1.2 This paper provides the Board of Directors with an update on the Board Assurance Framework (BAF) and the Principal Risks aligned to the 2026/27 Corporate Objectives.

2. Discussion

2.1 Current Board Assurance Framework

2.1.1 The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the Corporate Objectives.

2.1.2 At the Board meeting on 2 April 2026, the Board approved the Principal Risks for 2026/27.

2.1.3 The BAF has since been refined to ensure full alignment with the Trust's strategic priorities, incorporating updates agreed through the March 2026 Board Workshop and the Committees of the Board.

2.1.4 The 2026/27 BAF continues to be reviewed through Committees of the Board, with Principal Risks aligned to Safety and Quality Committee, Finance and Performance Committee and People and Partnerships Committee.

2.1.5 The Principal Risks for 2026/27 are as follows:

Principal Risk Number	Principal Risk	Exec Lead	5Ps	Risk Appetite	Risk Tolerance	Current score	Direction of score since last meeting
PR1 (26/27)	Patient safety and experience within the urgent and emergency care pathway including corridor care	CNO	Patients	Cautious	1-6	15	→
PR2 (26/27)	People experiencing Health inequalities	CNO	Patients	Cautious	1-6	12	→
PR3 (26/27)	Timely access to planned care	COO	Performance	Cautious	1-6	16	→
PR4 (26/27)	Timely access to cancer care	COO	Performance	Cautious	1-6	16	→
PR5 (26/27)	Timely access to urgent and emergency care	COO	Performance	Cautious	1-6	20	→
PR6 (26/27)	Timely access to diagnostic investigations	COO	Performance	Cautious	1-6	16	→
PR7 (26/27)	Experience of under-represented staff groups	CPO	People	Open	4-8	12	→

Principal Risk Number	Principal Risk	Exec Lead	5Ps	Risk Appetite	Risk Tolerance	Current score	Direction of score since last meeting
PR8 (26/27)	Experience of staff and levels of staff satisfaction	CPO	People	Open	4-8	12	→
PR9 (26/27)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	Open	4-8	12	→
PR10 (26/27)	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit	CFO	Productivity	Open	8-12	20	→
PR11 (26/27)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	Open	8-12	20	→
PR12 (26/27)	Ability to access required Capital to support an ageing estate	CFO	Productivity	Open	8-12	16	→
PR13 (26/27)	Delivery of the planned reduction in whole time equivalent workforce	CPO	Productivity	Open	8-12	20	→

2.1.6 There are currently 13 Principal Risks within the BAF. Since the previous Board report, no Principal Risk scores have increased and all scores remain unchanged following ongoing Executive review and scrutiny through the relevant Committees of the Board.

2.1.7 The following areas have been subject to focused discussion and are consistent with the key messages set out in the Executive Summary:

- Further review has been undertaken of PR1 (Patient safety and experience within the urgent and emergency care pathway). The title of the risk has been revised to include reference to eliminating corridor care, ensuring that the Principal Risk remains aligned to the Trust's operational improvement priorities and the focus of the transformation programme. Actions associated with PR1 have also been aligned to the Trust's Urgent and Emergency Care and Frailty Transformation Plan, strengthening the link between the Principal Risk, agreed transformation milestones and associated mitigating actions. The complementary Principal Risk relating to patient access, flow and performance continues to be managed separately through PR5 (Timely access to urgent and emergency care), with oversight through the Finance and Performance Committee.
- At its meeting on 22 September 2026, the Finance and Performance Committee noted that the risk score trajectories for PR3 (Timely access to planned care), PR4 (Timely access to cancer care), PR6 (Timely access to diagnostic investigations) and PR13 (Delivery of the planned reduction in whole time equivalent workforce) had been expected to reduce at this stage of the year; however, current scores have been maintained. This is consistent with previous Board discussion that risk scores should reflect the broader underlying risk position and be supported by evidence of sustained improvement over at least two quarters, rather than short-term improvement against individual indicators. Performance reports considered alongside the Strategic Risk Report demonstrated positive progress in a number of areas, including reductions in long waits for planned care and improvements in cancer and diagnostic performance trajectories. It should also be noted that some supporting indicators are subject to reporting and validation timeframes, meaning that the latest operational position may not yet be fully reflected in validated performance data. Further evidence of sustained improvement is therefore required before a reduction in these risk scores would be supported.

- PR9 (Failure to effectively manage staff absence and achieve Trust and National target rates) remains at a score of 12. The risk trajectory had anticipated a reduction in score by September 2026, with a target control date at the end of September 2026. However, due to the discontinuation of the Empactis pilot, the anticipated reduction has not been achieved. The risk trajectory and target control date will therefore be reviewed again through the next People and Partnerships Committee cycle, taking account of the timescales required to approve, implement and embed a replacement digital absence management system.

2.2 Review of Corporate Objectives and Principal Risks

- 2.2.1** During October and November 2026, the 2026/27 Corporate Objectives will be reviewed through the relevant Committees of the Board alongside the Principal Risks aligned to each strategic objective. This will enable Committees to consider progress against delivery of the Corporate Objectives alongside the risks that may impact their achievement and provide scrutiny and challenge on whether the current Principal Risk profile remains appropriate.
- 2.2.2** This will also include the review of partnership-related risks, following discussion at the Board of Directors in August 2026. A further update, including any recommended changes to the Principal Risk profile, will be provided to the Board at the next meeting.

2.3 Strengthening alignment with the SIP

- 2.3.1** There is also a plan to further strengthen the alignment between the BAF and delivery through the Single Improvement Plan (SIP). The proposed approach is to establish a clearer link between SIP delivery plans and Principal Risks, providing greater visibility of progress against key transformation and improvement programmes and how these contribute to the management and reduction of principal risks.

2.4 Operational High Risks for Escalation/De-escalation

- 2.4.1** Whilst there are currently no operational high risks escalated to the Board within the BAF, the Safety and Quality Committee has received an update on an operational risk relating to ongoing disruption within pathology services. The Committee noted that the risk remains subject to active management through established governance arrangements, with mitigations in place to support continuity of critical services and monitor any potential impact on patient care, service delivery and operational resilience. The position will continue to be reviewed through the Safety and Quality Committee. Any requirement for escalation to the Board will be considered through the Trust's established risk management and governance processes.

3. Financial implications

- 3.1** Any financial implications are captured within the Risk Register records and managed accordingly.

4. Legal implications

- 4.1** Any legal implications are captured within the Risk Register records and managed accordingly.

5. Risks

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

6. Impact on stakeholders

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

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

7. Recommendations

7.1 It is recommended that the Board of Directors:

- Note and approve the updates to the BAF.

Board Assurance Framework

2026/27

Board of Directors – September 2026

 **Patients** – deliver excellent care

 **Performance** – deliver timely, effective care

 **People** – be a great place to work

 **Productivity** – delivery value for money

 **Partnership** – be fit for the future

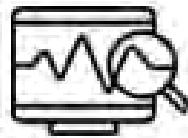
How the Board Assurance Framework fits in



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



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



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



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



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



Reporting: To make the Board Assurance Framework as easy to read as possible, we use colours to support the attention to important areas. It is recognised that elements of this document may not support accessibility standards, but this can be re-produced in an accessible form if required. Should this be required, please contact company.secretary@lthtr.nhs.uk by email.

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

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

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

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

Our strategic approach at a glance



Strategic Objectives



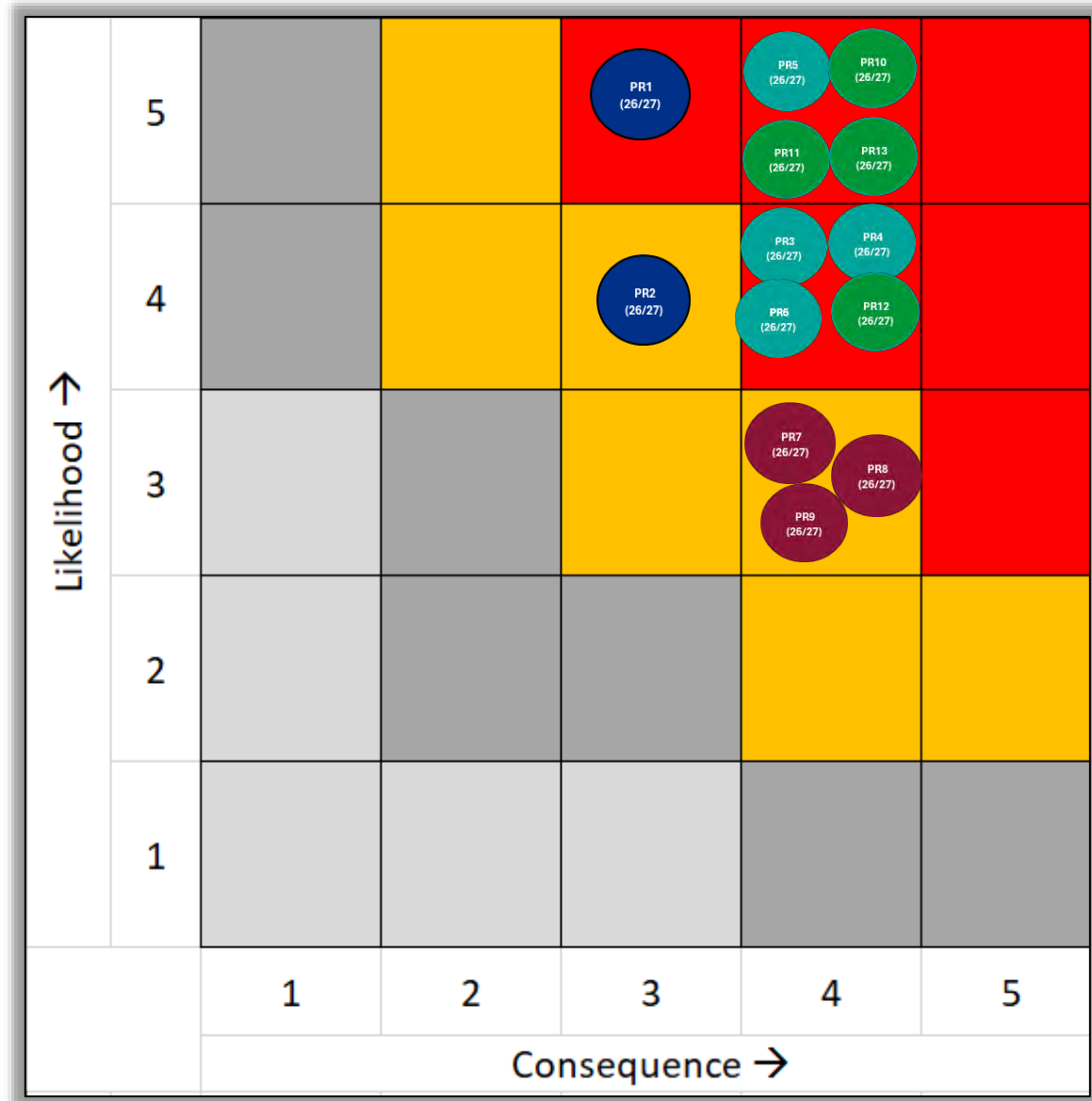
2026/27 Corporate Objectives



Principal Risk Management

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

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (26/27)	Patient safety and experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15	→
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PR10 (26/27)	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit	CFO	Productivity	FPC	Open	8-12	20	→
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PR12 (26/27)	Ability to access required Capital to support an ageing estate	CFO	Productivity	FPC	Open	8-12	16	→
PR13 (26/27)	Delivery of the planned reduction in whole time equivalent workforce	CPO	Productivity	FPC	Open	8-12	20	→



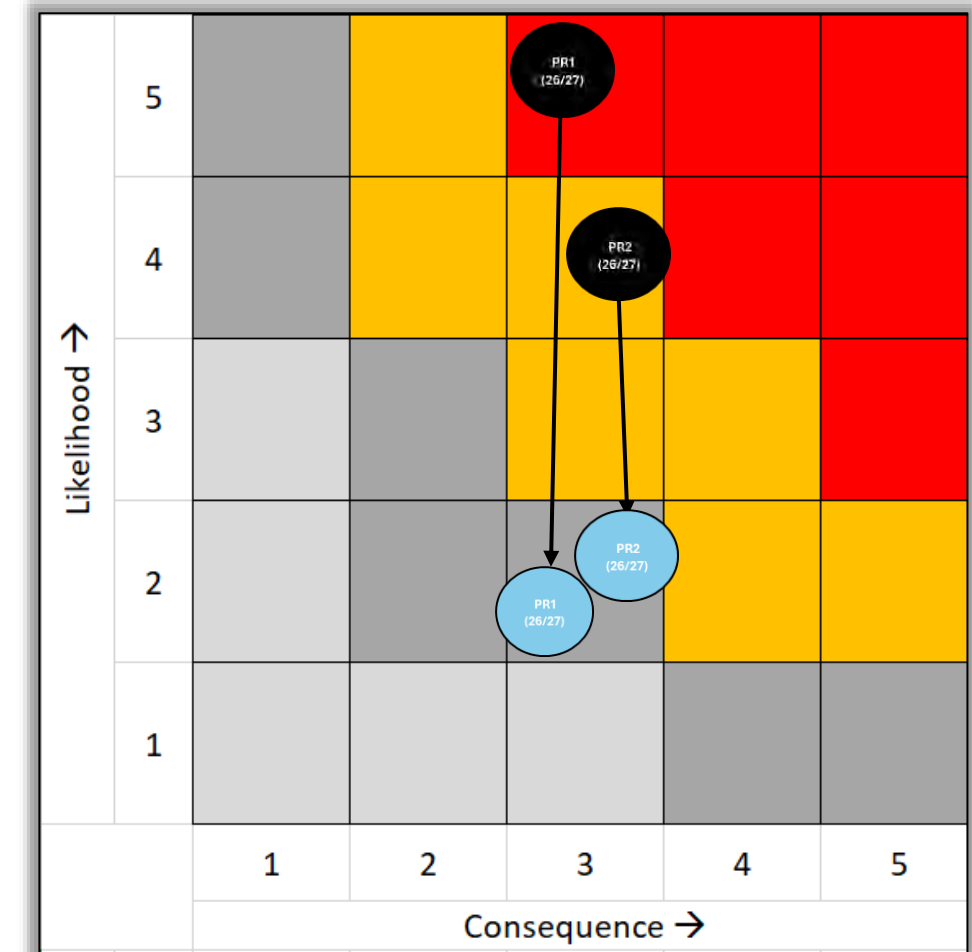
Key- Dark Blue = Patients, Turquoise = Performance, Red = People, Green = Productivity, Pink - Partnership

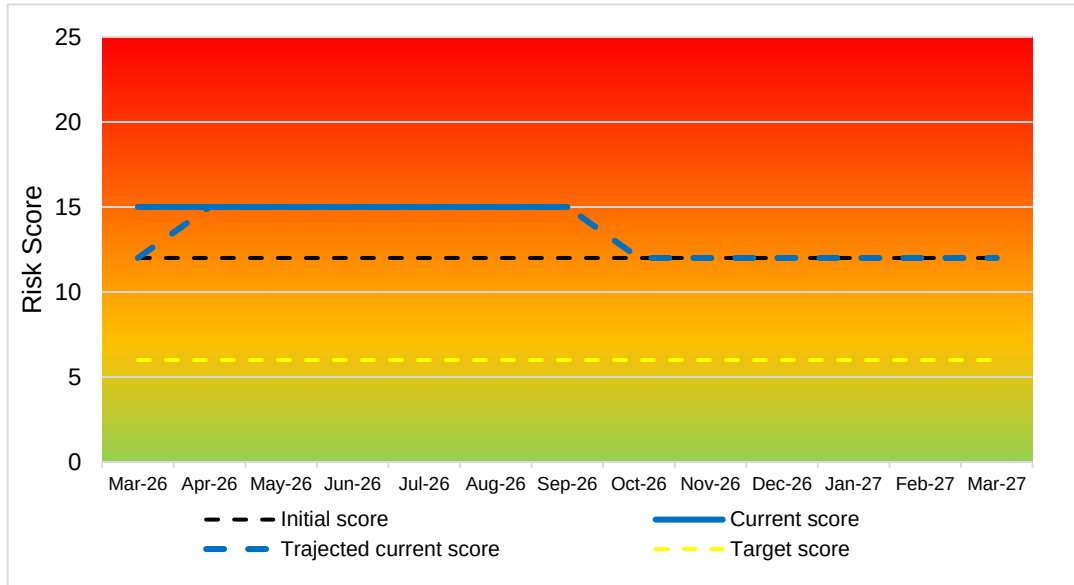
Patients: Deliver excellent care

Monitored through Safety & Quality Committee

The following 2026/27 corporate objectives are aligned to the **Patients** strategic objective:

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
1.1	Implement the national Maternity and Neonatal Improvement Plan and the Maternity Incentive Scheme	- Deliver the national Maternity and Neonatal Improvement Plan, which sets out a comprehensive framework for enhancing the safety, quality, and equity of care for mothers and babies. This includes - strengthening clinical leadership, - improving workforce capacity - embedding evidence-based practices across maternity and neonatal services. - Implementation will be supported by robust governance, continuous learning, and collaboration across the Integrated Care System.	- Reduction in sepsis, improved thermal stability - MEWS/NEWTT2 implementation & compliance - Adoption of evidence-based interventions - Sustained reduction in term admissions to NICU - Sustained improvements in application of Sepsis 6, smoking cessation, diabetes management - Improved staffing metrics & safety culture survey scores	No Risk identified
1.2	Undertake a fundamental specialty redesign adopting the principles of the ten-year health plan. Priority areas year 1: - Frailty - COPD - Heart Failure	- Redesign of those specialties involved in long term care, guided by the principles of the ten-year health plan. - Rethink how services are delivered, integrating care across settings, and aligning clinical pathways with population health priorities - Focus on prevention, early intervention, and multidisciplinary collaboration, ensuring that specialty services are more accessible and efficient.	- Reduction in emergency admissions for key LTC groups (e.g., COPD, heart failure, diabetes) - Reduction in avoidable 30-day readmissions - Improved LTC outcome metrics (e.g., HbA1c, spirometry stability, heart failure optimisation) - Reduced variation in outcomes between sites/services % of LTC pathways aligned to evidence-based guidance and 10-year plan principles	No Risk identified
1.3	Recognise the asset specialist services are to the organisation and the important role they play at LTH, delivering cutting edge care and being a catalyst for innovation and pioneering clinical practice	- Foster clinical excellence. - Invest in specialist expertise - Ensure that services are designed and delivered in a way that meets the diverse needs of the population. - Champion innovation and collaboration.	We can reduce unwarranted variation in both access to care and patient outcomes, ensuring that every individual receives equitable, timely, and effective treatment regardless of geography or circumstance.	No Risk identified
1.4	Design and deliver a children's and young people's plan to improve access to urgent and emergency care	Design and implement a comprehensive Children's and Young People's Plan. This plan will be developed in collaboration with healthcare professionals, education providers, local authorities, and most importantly children, young people, and their families	- Identifying and addressing barriers to care - Streamlined referral pathways - Enhancing the capacity and responsiveness of urgent care services. - Creation of a more accessible, responsive, and inclusive urgent care system.	No Risk identified
1.5	Improve outcomes and prevent harm	- Implement the Always Safety-First strategy 2026-2029 - Deliver medicines safety and optimisation programme - Continued implementation of PSIRF & demonstrate maturity in the approach to learning. - Deliver within the agreed C.difficile trajectory - Deliver annual safe staffing requirements	- Improved verification and reconciliation compliance - Delivery of Always Safety First and learning strategy - Deliver agreed C.difficile trajectory - Deliver Maternity Incentive Scheme - Deliver annual safe staffing requirements	No Risk identified
1.6	Reduce occupancy across UEC pathways	- Reduce routine boarding on ward areas - Eliminate corridor care in the Emergency Department - Reduce ambulance delays	- Reduce routine boarding on ward areas - Eliminate corridor care in the Emergency Department - Reduce ambulance delays	Risk identified
1.7	Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways	Work across all pathways to implement agreed actions to further reduce health inequalities	Work across all pathways to implement agreed actions to further reduce health inequalities	Risk identified



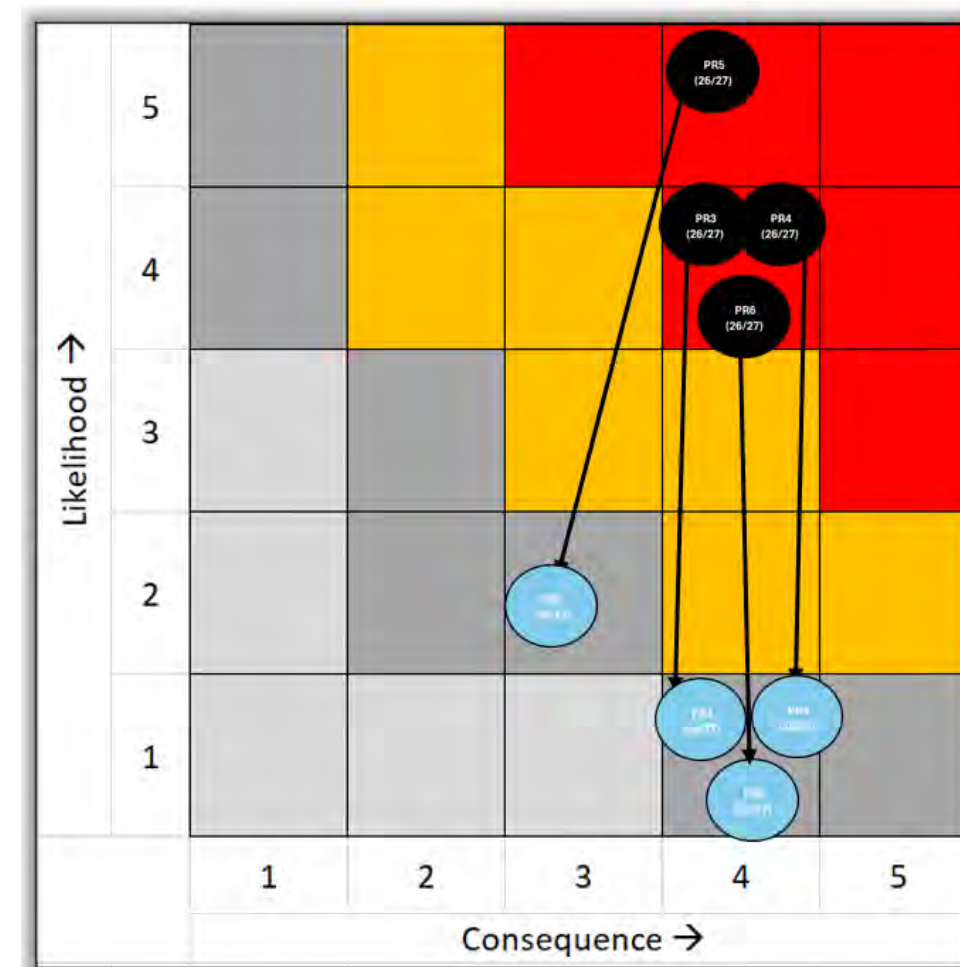
Strategic Objective: Patients					Corporate Objective: Reduce occupancy across UEC pathways					Overall Assurance Level					Low																																			
Principal risk 1 (26/27) (ID 2102)	Risk Title:	Patient safety and experience within the urgent and emergency care pathway - Eliminating Corridor Care								Risk Score Tracker 																																								
	Risk Description :	There is a risk that patient safety and experience within the urgent and emergency care pathway may be negatively impacted due to consistently high service demand, delayed handover from ambulances, long waiting times, corridor care and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in increased patient safety incidents, reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.																																																
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target											5						4						3						2						1							1	2	3	4	5
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Director	Chief Nursing Officer	5Ts status	Treat																																															
Date risk opened	05/12/24	Date of last review	18/09/2026																																															
		Target control date	31/03/27																																															
Controls		Gaps in Controls		Assurances							Gaps in Assurances																																							
- Twice annual nurse staffing assessments. - Patient experience and Involvement plan. - Patient Experience & Involvement Group. - National OPEL Framework. - L&SC daily Gold Command meetings. - Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). - Urgent & Emergency Care Delivery Board. - Urgent & Emergency Care Picker Survey Action Plan. - Discharge Improvement Plan. - UEC Improvement Director in place. - Refreshed patient experience approach being implemented across priority services using Northumbria approach.		- Community demand for primary and UEC services. - Community ability to increase the number of new patients being seen in 2 Hour Urgent care. - Alternatives to Emergency Care. - Ageing estate and environment. - Sub-optimal escalation areas. - Financial constraints. - Inpatient Picker survey identifies lower than expected experience outcomes. Gap in the required number of beds. - Patients cared for outside of designated bed spaces. - Not Meeting Criteria to reside >5% target.		<u>Level 1 Assurance</u> - Complaints and concerns – approx. less than 1% versus attendances. - Weekly PSIRF oversight panel reviewing incidents and emerging themes - Weekly and fortnightly forums with CNO/CMO/COO supporting escalation & speaking up culture. - Safety and Quality (S&Q) dashboard tracks S&Q metrics and includes the ED dashboard. - Boarding position monitored via S&Q dashboard, supported by policies to maintain care standards. - UEC performance indicators (triage and time to clinician), with improvements at CDH and stable position at RPH. - STAR patient experience and Friends & Family have some areas of positive performance. <u>Level 2 Assurance</u> - Patient Experience & Involvement Group reports, Picker Survey reports, Freedom to Speak Up Arrangements reported to Safety & Quality Committee. - Quarterly PSIRF report providing overview of significant incidents and trends, Bi annual mortality and medication safety reports to Safety and Quality Committee. - GMC resident doctor survey reported to People Committee. <u>Level 3 Assurance</u> - UEC survey reflecting outcomes ‘about the same’ as other Trusts							- Time to see a clinician at RPH consistently exceeds the 60 min average target. - Inpatient survey identified medicine at RPH most prevalent area of less positive experiences. - The CDH site UEC pathway is demonstrating increased occupancy levels leading to longer length of stay at the start of the pathway. - Friends and Family Test – gaps related to communication, waiting times and overall experience. - Summary Emergency Department Indicator Table (SEDIT) outcomes below peer																																							
Risk Treatment																																																		
Action			Action Owner	Due Date	Done Date	Action Progress Update																																												
Increase capacity in 2 hour Urgent Care (care connexions).			S. Morrison	31.03.26 31.07.26 30.09.26	Stood Down	Sep 26: This action has been removed. Following agreement with LSCFT, the joint improvement focus has moved to frailty, with delivery now captured through the Frailty Collaborative improvement workstream.																																												
Deliver the year 1 Frailty collaborative improvement workstream			S. Morrison	31.12.26		Sep 26: Community response in ED and daily huddles are live, with an aim of a 20% reduction in 12-hour waits for patients aged 65+. The September milestone focuses on a consistent frailty presence within ED/EEMAC, with an aim of supporting 7 patients aged 65+ per day. The next milestone is the frailty therapy and medical ‘perfect ward’ model in October 2026.																																												
Commission review of patient experience with the focus on improving experience.			S. Morrison	31.10.26		Sep 26: Draft patient experience review received. Final report due to be presented to Safety & Quality Committee in October 2026.																																												
Develop Mental Health Review Centre (with LSCFT) adjacent to ED to reduce ED waits for mental health patients.			S. Morrison	30.07.27		Sep 26: Plans have been approved and construction continues in line with the agreed plan, with completion scheduled for July 2027.																																												
UEC Improvement Programme delivery			S. Canty	31.03.27		Sep 26: EEMAC has been implemented and the 24/7 Medical Ambulatory Care model has launched in line with plan. The next milestone is delivery of NWS direct pathways to MDU in October 2026, followed by work to demonstrate the impact of site management and length-of-stay improvements in November.																																												
Undertake Single Point of Access self-assessment with LSCFT team.			S. Morrison	01.10.26		Sep 26: SPOA self-assessment completed and workshop scheduled for October 2026. Agreed plan to be co-designed with partners across Central Lancashire to outline the future service.																																												

Strategic Objective: Patients		Corporate Objective: Reduction in Health Inequalities across core20plus5 for adults and children and frailty pathways					Overall Assurance Level			Medium		
Principal risk 2 (26/27) (ID 2103)	Risk Title:	People experiencing Health inequalities							Risk Score Tracker --- Initial score — Current score - - - Trajected current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)			
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.										
	Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious	Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target							
	Director	Chief Nursing Officer	5Ts status	Treat								
Date risk opened	05/12/24	Date of last review	18/09/2026									
		Target control date	31/03/27									
Controls		Gaps in Controls		Assurances				Gaps in Assurances				
- Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. - LTH Health Improvement Plan, developed in conjunction with L&SC system partners. - Health Inequalities Group. Health Inequalities Patient Tracking List (PTL) Group. - Health literacy group relating to communication with patients. Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).		- Commissioning arrangements are led by the ICB. - The Trust has no Public Health Consultant. - Anchor institute plan is under review to link to other plans. - Anchor institute group to be established. - Absence of a defined approach to measuring and managing reduction in health inequalities		<u>Level 1 Assurance</u> - Oversight of Health Improvement Plan delivery through Health Inequalities Group <u>Level 2 Assurance</u> - Monthly chairs reporting to Safety & Quality Committee - Bi-annual update on Health inequalities to Safety & Quality Committee. <u>Level 3 Assurance</u> - Annual compliance NHS statement on information on Health Inequalities – data does not suggest there are barriers for patients from areas of lower deprivation to accessing elective care services. - Quarterly Report to ICB on Health Inequalities.				- Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient’s ethnicity either unknown or not stated for Central Lancashire. - Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability. - Challenges in demonstrating the impact of actions on reducing health inequalities, pending further development of data and reporting.				
Risk Treatment												
Action			Action Owner	Due Date	Done Date	Action Progress Update						
Establish an approach to routine access to health inequalities data.			A. Brotherton	31.10.26		Sep 26: Agreement to provide an outline of the phased improvement for health inequality data by September 2026.						
Support case to approve the data sharing agreements between primary and secondary care.			A. Brotherton	31.12.26		Sep 26: Progress continues to be dependent on the information governance arrangements being in place and currently the only route to secure the agreement is through discussion with every individual GP practice across Lancashire and South Cumbria. The CSIO continues to work with the ICB Medical Director to explore solutions.						

Performance: Deliver timely, effective care
Monitored through Finance & Performance Committee

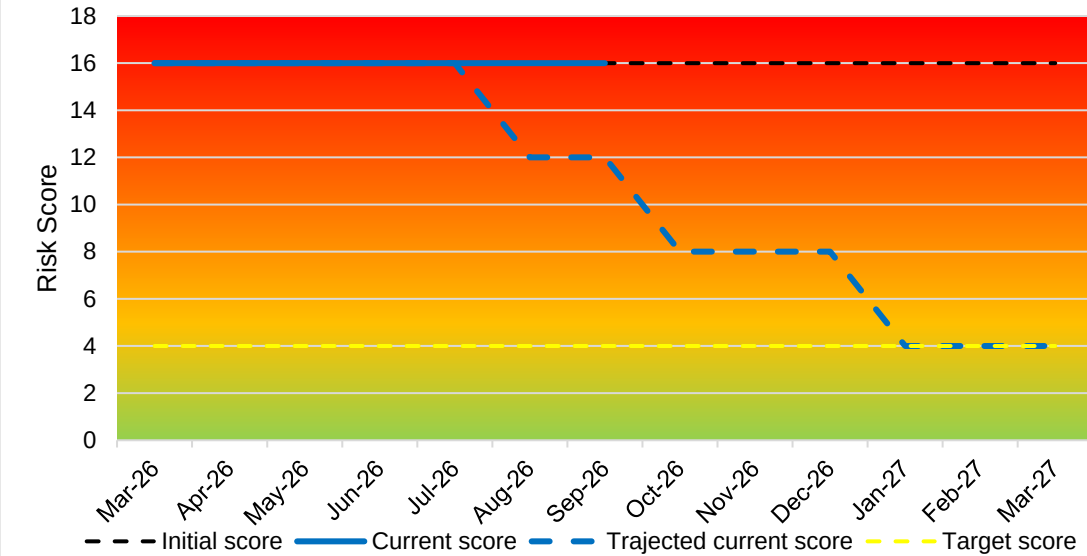
The following 2026/27 corporate objectives are aligned to the **Performance** strategic objective:

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
2.1	Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer	Redesign care pathways to be more efficient, reducing unnecessary delays and handoffs. Improved communication, both between healthcare professionals and with patients, will ensure that individuals are well-informed, supported, and actively involved in their care journey.	- Meet and exceed national cancer standards. - Achievement of percentage compliance for Faster Diagnosis Standards, 62 day referral to treatment and 31 days for treatment following a decision to treat as agreed in the annual plan. - Ensuring timely diagnosis, treatment, and follow-up - Fostering trust and confidence in our services.	Risk identified
2.2	Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards	- Co-design and standardise UEC pathways across providers to reduce duplication and improve consistency, working through the ICS urgent care networks - Streamline handoffs, improve communication, and reduce waiting - Explicitly targeting below-average UEC experience and long length of stay (LoS) for people presenting with mental health needs - Reduce urgent and emergency care waiting times in line with agreed plan: Adults - 82%, Children - 95%	- Achieve and sustain performance at or better than national average - Same Day Emergency Care (SDEC) utilisation: % of eligible patients managed via SDEC pathways - Reduction in serious incidents related to deterioration/escalation delays; timely delivery of sepsis bundles in urgent pathways - ED Friends & Family Test (FFT) positive score: Sustained improvement quarter-on-quarter	Risk identified
2.3	Implement the strengths-based approach Days Kept Away from Home across all services	- Embedding a culture that values independence, supports recovery, and reduces unnecessary hospital admissions. - Fostering of multidisciplinary collaboration, enabling teams to work together to create care plans that are proactive, preventative, and tailored to each person's strengths and circumstances.	- Reduction in days kept away from home - Improvement in length of stay	No Risks identified
2.4	RTT - Eliminate 52-week breaches and achieve compliance trajectories as agreed in the annual plan	Reduce elective care waiting times in line with agreed and funded plan	- Eliminate all instances of a patient waiting longer than 52 weeks for treatment - Meet and exceed locally agreed compliance trajectories	Risk identified
2.5	Diagnostics - Achievement of the 6 week diagnostic waiting times performance trajectories	Reduce diagnostic waiting times	Meet and exceed locally agreed compliance percentages	Risk identified



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

Strategic Objective: Performance					Corporate Objective: RTT - Eliminate 52-week breaches and achieve compliance trajectories as agreed in the annual plan					Overall Assurance Level		Medium																															
Principal risk 3 (26/27) (ID 2314)	Risk Title:	Timely access to planned care								Risk Score Tracker --- Initial score — Current score - - - Trajected current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal																																	
	Risk Description:	There is a risk that there is insufficient capacity to deliver the required activity levels needed to achieve performance trajectories and deliver timely access to clinical assessment and treatment. Capacity constraints relate to insufficient workforce and/or physical estate shortfalls. Shortfalls in clinical capacity could result in patient harms associated with a delay in timely access to planned care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.																																									
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	↑ Likelihood <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> → Consequence ● Initial ● Current ● Target					5											4							3							2							1		
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Director	Chief Operating Officer	5Ts status	Treat																																								
Date risk opened	02/04/26	Date of last review	14/09/2026																																								
		Target control date	31/03/27																																								
Controls				Gaps in Controls				Assurances		Gaps in Assurances																																	
26/27 Annual activity & Performance plans have been outlined to deliver reductions in long waiting RTT targets, waiting list reduction and improved 18-week compliance in line with agreed trajectories. Plans include monthly trajectories and associated action plans. - Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. - PEP+ (Patient Engagement Portal) and AI functionality to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. - Weekly Operations Board in place to track performance and delivery of actions linked to improvement trajectories. - A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. 6-4-2 protocols in place to drive optimal use of theatre capacity. - Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented - Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements. - Capacity & Demand modelling has been undertaken for key specialties. - Independent sector capacity is commissioned to support delivery of the required activity levels. - Pilot of AI Robotic (LLM) RTT validation underway with high success rates identified – being mobilised across full RTT PTL.				- Where specialties have a Capacity & Demand gap which cannot be mitigated via improved productivity, there is a need to resource additional capacity. - Restricted admin capacity to backfill short notice procedure cancellations. - Limited admin and clerical resource to support the ‘double entry’ required to accurately administrate the independent sector activity. - Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays - Limited clinician appetite to deliver additional non-core activity required to deliver the required performance. - Independent sector (IS) capacity is insufficient to meet the requirements of the organisation or IS providers are unable or unwilling to support the case mix requested.				<u>Level 1 Assurance</u> - Live PTL performance report and Validation reports. <u>Level 2 Assurance</u> - Oversight in Divisional Improvement Forums, Operations Board and F&P Committee. - Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> - Fortnightly tiering meetings in place to track progress. - Performance agenda established within RPOM		- Delays in concluding some harm reviews. - Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. - Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting. - Lack of performance and productivity data visibility at speciality level																																	
Risk Treatment																																											
Action		Action Owner	Due Date	Done Date	Action Progress Update																																						
Commission and mobilise additional independent sector capacity		K Foster Greenwood	~~31.05.26~~ 31.07.26	23.07.26	Aug 26: Independent Sector capacity commissioned and mobilised to support delivery of RTT trajectories.																																						
Resource requirement to support 10 x AI PIFU roll out to be defined and investment secured.		K Foster Greenwood	~~31.07.26~~ 31.10.26		Sep 26: Outcome of NHS Digital bids still not confirmed. Roll out subsequently delayed. Resource currently sufficient to support the development of 1 specialty. Scoping options with local provider Trusts to secure interim funding. Due date extended until end Oct 26.																																						
Recruitment & mobilisation into Internal Capacity Business case		K Foster Greenwood	~~31.08.26~~ 30.11.26		Sep 26: Recruitment is ongoing. 5 posts have been appointed and are in pre-employment stages. 29 posts are at advert stage. Target completion date extended.																																						
Gateway review of IS contract		K Foster Greenwood	31.10.26		Sep 26: New action.																																						

Strategic Objective: Performance				Corporate Objective: Improve patient experience through a focus on valuing patients' time by developing streamlined pathways and better communication, leading to the delivery of national standards for cancer				Overall Assurance Level		Medium		
Principal risk 4 (26/27) (ID 2315)	Risk Title:	Timely access to cancer care							Risk Score Tracker  Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal			
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to cancer care as a result of critical workforce or other capital resource gaps such as Diagnostic equipment. This could result in patient harms associated with a delay in timely access to cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.										
	Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target							
	Director	Chief Operating Officer	5Ts status	Treat								
Date risk opened	02/04/26	Date of last review	14/09/26									
		Target control date	31/03/27									
Controls				Gaps in Controls				Assurances		Gaps in Assurances		
- Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. - Weekly Operations Board established to track performance and delivery of actions linked to improvement trajectories. 6-4-2 protocols in place to drive optimal use of theatre capacity. - Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented - Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements.				- Where specialties have a Capacity & Demand gap which cannot be mitigated via improved productivity, there is a need to resource additional capacity. - Limited clinician appetite to deliver additional non-core activity required to deliver the required performance. - Inability to successfully recruit into nationally hard to recruit to posts e.g. Oncology - Restricted admin capacity to backfill short notice procedure cancellations. - Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays - Lack of community capacity with the closure of Community Healthcare Hub and reduced capacity at Longridge resulting in high bed occupancy and increasing the risk of capacity related elective and cancer cancellations - RTF funding secured was at half the value of the submitted bid. - Limited digital and validation capacity to support the AI Robotic RTT validation pilot.				<u>Level 1 Assurance</u> - Live PTL performance report and Validation reports. - Harm reviews process in place for >104-day cancer pathway patients. <u>Level 2 Assurance</u> - Oversight in Divisional Improvement Forums, Operations Board and F&P Committee. - Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> - Fortnightly tiering meetings in place to track progress - Performance agenda established within RPOM		- Delays in concluding some harm reviews. - Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. - Inability to assess the risk for patients on surveillance pathways. - Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting. - Lack of performance and productivity data visibility at tumour group level		
Risk Treatment												
<u>Action</u>		<u>Action Owner</u>		<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>						
Develop a Cancer productivity dashboard to monitor performance against best timed pathways to inform improvement plans and performance delivery.		K Foster Greenwood		~~30.06.26~~ 30.09.26	14.09.26	Sep 26: 11 tumour groups are now included in the cancer performance dashboard						
Recruitment & mobilisation into Internal Capacity Business case		K Foster Greenwood		~~31.08.26~~ 30.11.26		Sep 26: Recruitment is ongoing. 5 posts have been appointed and are in pre-employment stages. 29 posts are at advert stage. Target completion date extended.						

Strategic Objective: Performance					Corporate Objective: Improve patient experience and performance in Urgent and Emergency Care through the delivery of the 4 hour, 12 hour and ambulance handover standards					Overall Assurance Level			Low																															
Principal risk 5 (26/27) (ID 2104)	Risk Title:	Timely access to urgent and emergency care								Risk Score Tracker --- Initial score — Current score - - - Trajected current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectory reset for 26/27)																																		
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust’s reputation and regulatory compliance.																																										
	Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr></table> Consequence → 12345 ● Initial ● Current ● Target										5						4						3						2						1					
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Director	Chief Operating Officer	5Ts status	Treat																																									
Date risk opened	05/12/24	Date of last review	14/09/26																																									
		Target control date	31/03/27																																									
Controls				Gaps in Controls				Assurances				Gaps in Assurances																																
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established. • 45 min Release to Rescue protocol implemented • Additional stretch targets agreed with system partners • UEC Programme Board Established and UEC Improvement Director in post • Extended Emergency Medicine Ambulatory Care in place				• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The environment and estate are sub-optimal.				<u>Level 1 Assurance</u> • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm. <u>Level 2 Assurance</u> • Urgent & Emergency Care and Community Transformation Board provides monthly monitoring of all improvement actions across the system. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. <u>Level 3 Assurance</u> • Fortnightly tiering meetings in place to track progress • Performance data presented to RPOM.				• High bed occupancy levels (above 92%). • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12-hour total wait time in the department, are not meeting the Trust targets. • Ambulance turnaround times are not meeting the Trust targets.																																
Risk Treatment																																												
Action		Action Owner	Due Date	Done Date	Action Progress Update																																							
UEC improvement programme (Phase 1)		S Canty	~~31.08.26~~ 30.10.26		Sep 26: Re-design work continues with the new Acute Medical Model of Care with plans to launch 24/7 SDEC by the end of Aug 26. Frailty SDEC incremental launch is ongoing with daily multi-partner huddles taking place.																																							
Publication of a Standard Operating Procedure for MDT Board and Ward Rounds with aligned audit and training program		R Sansbury	~~30.06.26~~ 31.07.26	31.07.26	Aug 26: The SOP has been approved through the Nursing Midwifery and Allied Health Professionals Board in June 2026, The Clinical Reference Group in June 2026 and the Senior Leadership Team in July 2026 to allow both clinical and operational approval of the standards and process.																																							

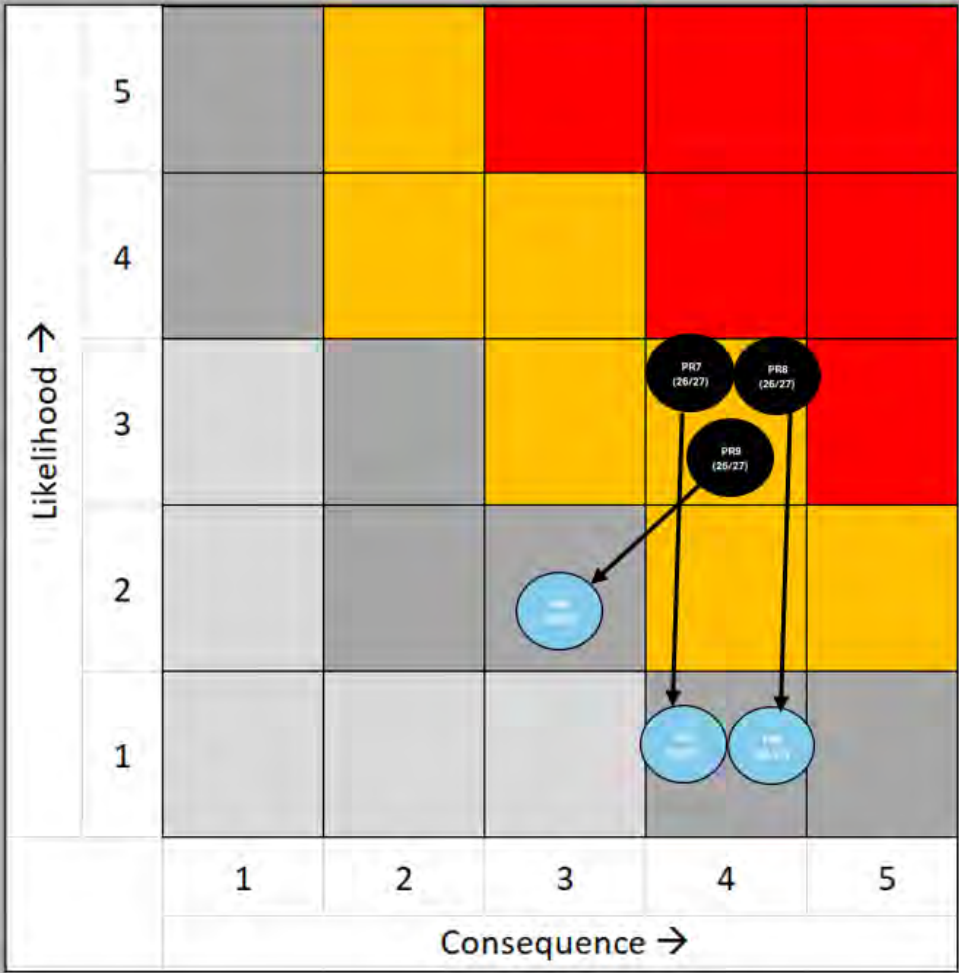
Strategic Objective: Performance				Corporate Objective: Diagnostics - Achievement of the 6 week diagnostic waiting times performance trajectories				Overall Assurance Level		Medium																																											
Principal risk 6 (26/27) (ID 2188)	Risk Title:	Timely access to diagnostic investigations						Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectory reset for 2026/27)																																													
	Risk Description:	There is a risk of delays in the completion of diagnostic investigations linked to cancer and elective pathways of care due to high levels of demand, shortfalls in capacity, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely diagnosis, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.																																																			
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td></td></tr></table> Consequence → ● Initial ● Current ● Target								5							4					●	●	3							2							1					●			1	2	3	4	5	
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Director	Chief Operating Officer	5Ts status	Treat																																																		
Date risk opened	03/06/25	Date of last review	14/09/26																																																		
		Target Control date	31/03/27																																																		
Controls				Gaps in Controls				Assurances				Gaps in Assurances																																									
- Diagnostic Improvement Group has been established to monitor progress of all improvement trajectories, support demand management, the use of technology and monitor productivity. - All Diagnostic modalities have undertaken a capacity and demand analysis and set improvement trajectories. - Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority using ‘D codes’ to support scheduling the most clinically urgent. - Diagnostic waiting validation processes are in place to ensure all capacity is effectively used. - Additional capacity has been commissioned within the 26/27 agreed MTP. - Weekly monitoring of cancer PTLs to reduce any delays is in place supported by a day zero PTL approach with tumour specific action plans in place. ICB support and performance monitoring re Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. - Weekly Chief Operating Officer monitoring forum for core diagnostic modalities. - Weekly Performance Recovery Group established to monitor performance. - Mutual aid support enacted via neighbouring Trust for Echo - Additional capacity mobilised (non-recurrently) for Echo				- Lack of capacity to deliver comprehensive diagnostic waiting list validation. - Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes. - Physical estate and capital equipment constraints limit available capacity. - Limited influence re external (primary care) demand management.				<u>Level 1 Assurance</u> - Live PTL performance report. - Validation reports. - Datix incident reporting of any treatment delay related harms – review via SI/PSIRF processes with shared learning reports. - Benchmarking data – model hospital, GIRFT, etc <u>Level 2 Assurance.</u> - Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. - Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> - DM01 improvement plan and trajectory in place monitored through NHS England oversight arrangements.				- Data sets lack inequalities data visibility to assess the risk of poorer outcomes between patient groups on PTLs - Datix incident reporting to assess harms of treatment delays is retrospective																																									
Risk Treatment																																																					
Action		Action Owner		Due Date		Done Date		Action Progress Update																																													
Develop a Diagnostic productivity dashboard to monitor performance against best timed pathways to inform improvement plans and performance delivery.		K Foster Greenwood		30.06.26 30.09.26				Sep 26: Significant work has taken place to provide improved visibility of key diagnostics including CDC delivery. Final amendments are being completed by end of September. Recruitment has been delayed due to One LSC internal processes which will impact on the wider system wide diagnostic dashboard development																																													
Recruitment & mobilisation into Internal Capacity Business case		K Foster Greenwood		31.08.26 31.10.26				Sep 26: Recruitment is ongoing. 5 posts have been appointed and are in pre-employment stages. 29 posts are at advert stage. Target completion date extended.																																													

People: Be a Great Place to Work

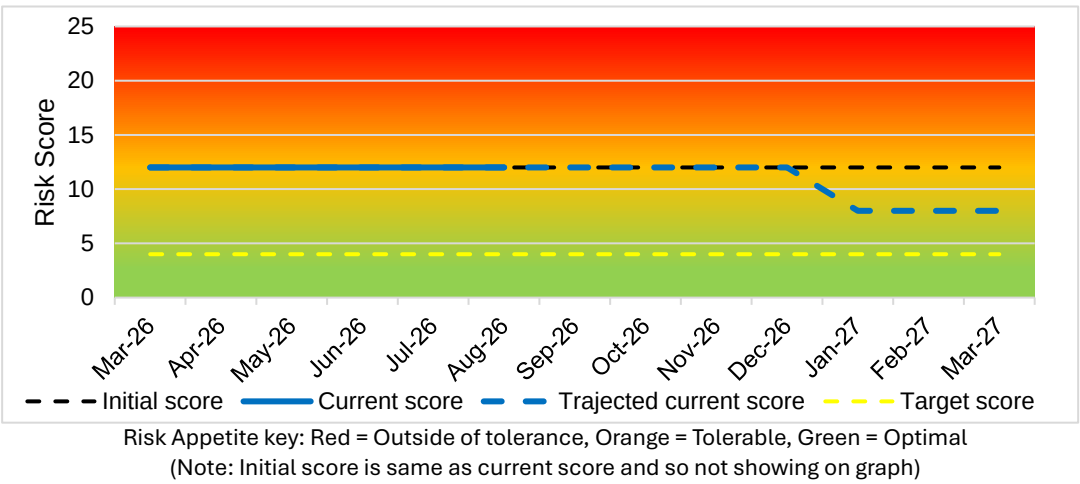
Monitored through Workforce Committee & Education, Training & Research Committee

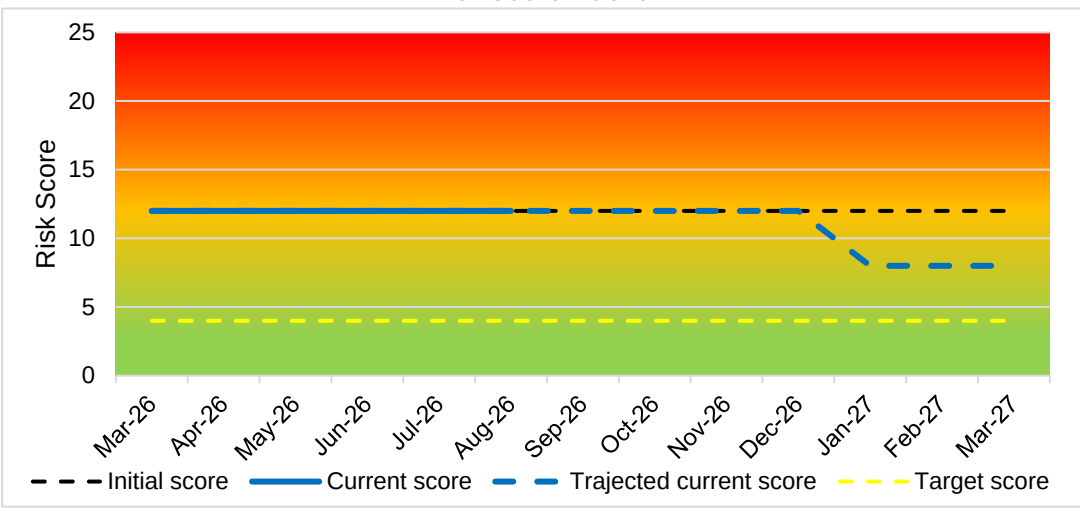
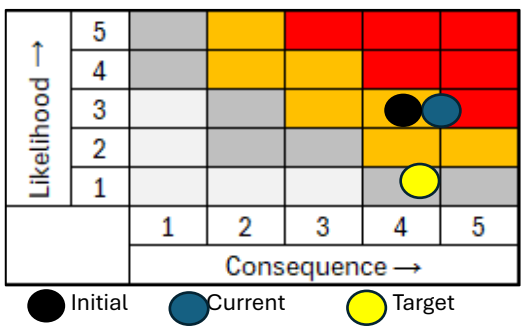
The following 2026/27 corporate objectives are aligned to the **People** strategic objective:

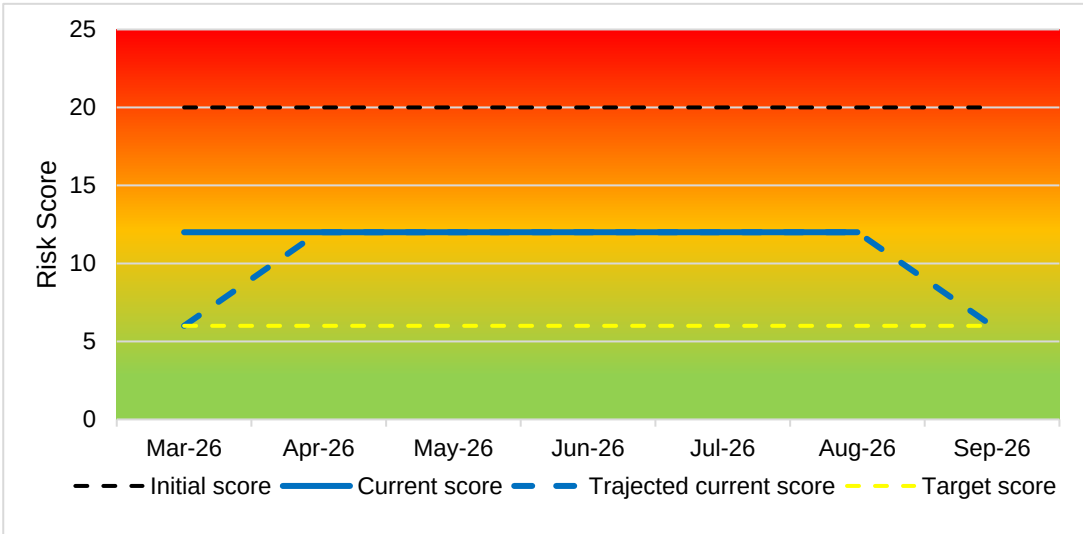
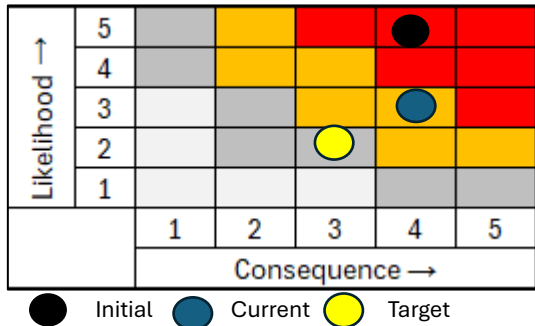
CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
3.1	Equip all our colleagues, including the Board, with the improvement skills, knowledge and confidence to drive improvements within their teams and services	Expand the current programme to include giving teams an understanding of the population health position	Increased % workforce training in improvement skills and methodology	No risk identified
3.2	Strengthen the confidence and capability of leaders	- Roll out a range of profession specific leadership and management development programmes. - Invest in the develop of the senior leadership team in the organisation. - Create a senior leadership development talent map and succession plan. - Increase the performance of teams through clear cascaded objective setting process and enhanced personal development planning.	- Delivery and strong attendance at leadership development programmes. - Positive evaluation feedback and improved leadership capability as measured through appraisal. - Improved staff survey outcomes linked to leadership behaviours, increased use of TED at team level, appraisal compliance and increased number of colleagues with objectives and development plans.	No risk identified
3.3	Improve the experience of work of colleagues with protected characteristics	- Complete process for Antiracist framework. - Deliver a talent programme for colleagues with protected characteristics. - Increase confidence in disclosing disability and social economic background. - To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care.	- To achieve bronze level of Antiracist framework. - Reduced levels of discrimination reported by Black, Asian and Minority Ethnic colleagues. - Reduced levels of bullying and harassment reported by Disabled colleagues. - Increased, proportional representation at more senior levels of colleagues with protected characteristics.	Risk identified
3.4	Support the health, wellbeing, safety and attendance of our workforce	- To implement a digital sickness absence management tool. - Providing targeted health and wellbeing to support colleagues with protected characteristics or from disadvantaged social economic backgrounds to remain well at work. - Taking action to reduce levels of violence and aggression shown towards colleagues from patients, visitors and other colleagues.	- Reduction in levels of sickness absence. - Reduction in the overall incidents of violence and aggression in the workplace. - Improved staff survey outcomes in relation to wellbeing support and colleagues feeling well at work.	Risk identified
3.5	Enhance colleague experience and levels of staff satisfaction	- Embed the colleague engagement approach, to ensure colleagues have a voice and involved in sharing ideas for improvement. - Increase levels of team effectiveness and engagement through greater utilisation of the TED tool. - Support cultural transformation through relaunching our values, leadership behaviours and development of a cultural dashboard.To enhance the governance and leadership within the Board of Directors through the provision of a Board development programme.	- Improved levels of colleague engagement and staff satisfaction across all of the NHS People Promise Indicators. - Increase NHS Staff Survey response rate.	Risk identified



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

Strategic Objective: People					Corporate Objective: Improve the experience of work of colleagues with protected characteristics					Overall Assurance Level					Medium																																										
Principal risk 7 (26/27) (ID 2316)	Risk Title:	Experience of under-represented staff groups								Risk Score Tracker 																																															
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust, including those in under-represented staff groups. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.																																																							
	Committee	People and Partnerships Committee	Risk Appetite and Tolerance		Open		<table><tr><td rowspan="5">Likelihood ↑</td><td>5</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr><tr><td colspan="2"></td><td colspan="5">Consequence →</td></tr></table> ● Initial ● Current ● Target						Likelihood ↑	5						4						3				●		2				●		1								1	2	3	4	5			Consequence →				
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Date risk opened	02/04/26	Date of last review		02/09/26																																																					
		Target control date		31/03/27																																																					
Controls				Gaps in Controls				Assurances				Gaps in Assurances																																													
- Our People Plan, Equality, Diversity and Inclusion (EDI) Policy and Strategy. - Single Improvement Plan. - EDI mandatory training. - Supporting Disability in the Workplace policy and agreement. - Trans and non-binary policy. - Equality Impact Assessment policy and supporting toolkit. - NHSE 8 High Impact Actions & NHS People Promise. - NHS Staff Survey action plan. - Culture programme, including Zero Tolerance campaigns. - Freedom to Speak Up Policy, Process and Champions. - Employee Relations policies and processes. - Trust Values/Best Version of Us/Leadership in Lancs frameworks. - Core People Management Skills programme. - EDI resources/education/toolkits - Staff ambassador forums for colleagues with protected characteristics (Ethnicity, Disability and Neurodiversity, LGBTQ+). - Staff engagement offer - Team Engagement and Development (TED) Tool and toolkit				- No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. - ESR Declaration rates for colleagues with a long-term condition or disability. - EQIA process/check and challenge in respect of EIA findings. - Variable local application of inclusive management practices and management of poor behaviours - Continue to await mandates and directives following the High Court ruling with regards to protected characteristics of sex.				<u>Level 1 Assurance</u> - EDI Annual Report - Suite of NHS Staff Survey reports and corporate level action plan. - Monthly reporting of participation with TED Tool. - Quarterly reporting of National Quarterly Pulse data. <u>Level 2 Assurance</u> - L&SC ICS ED&I Group. - EDI Strategy monitoring. - Our People Plan Strategy Monitoring. - Single Improvement Plan reporting. - People and Partnerships Committee <u>Level 3 Assurance</u> - Internal Audit review of ED&I in 2023/24 – Substantial Assurance. - WRES/WDES, EDS2022, North West Anti-Racist Framework and North West EDI Assurance processes.				- Challenges in ability to drill down into the NHS Staff Survey data from a minority group/divisional basis due to low numbers and confidentiality. - Improvement opportunities identified through WRES (appointment from shortlisting, discrimination from managers, Board membership) - Improvement opportunities identified through WDES (entering formal capability, experience of B&H or abuse, feeling valued). - WRES and WDES reporting is available annually only. - Variable Staff Survey response rates across protected characteristic groups. - Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) - Ability to measure progress in Divisions and Departments with regard to actions taken to address lower levels of staff satisfaction and engagement. - Challenges in demonstrating reach, awareness and uptake of EDI support and communications across the workforce.																																													
Risk Treatment																																																									
<u>Action</u>		<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>																																																				
Achieve Bronze Level of the Anti-Racist Framework to improve the experience of ethnic minority colleagues in relation to discrimination		M Davis	30.03.27		August 26: Meeting held with the Chief Executive mid-August to discuss actions required in respect of "leadership" - role of the Executive sponsor and Executive team objectives were also discussed. Process for raising concerns in respect of discrimination also discussed at length with a paper now requested to support potential solutions.																																																				
Implement a dedicated Talent Management programme for under-represented groups to increase diversity at Band 8a and above		M. Davis	31.01.27		August 26: Project to be progressed by the new Band 7 Organisational Development Practitioner who is due to commence in role on 22nd September 2026.																																																				
Increase managers' skills and competence to support colleagues with protected characteristics throughout the employee lifecycle		M. Davis	30.03.27		August 26: Video resource in pre-production to support line managers to have compassionate conversations in relation to long-term conditions/disability. Task and finish group established (first meeting scheduled for 7th September 2026) to resolve issues being experienced in respect of reasonable workplace adjustments, actioning access to work recommendations and procurement/reimbursement.																																																				

Strategic Objective: People						Corporate Objective: Enhance colleague experience and levels of staff satisfaction						Overall Assurance Level				Medium			
Principal risk 8 (26/27) (ID 2317)	Risk Title:	Experience of staff and levels of staff satisfaction										Risk Score Tracker 							
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues or prospective employees across the Trust. This could result in negative experience for staff, adverse impact for colleagues with a protected characteristic, inability to retain a skilled and valued workforce, staff absence, regulatory intervention, and legal action.																	
	Committee	People and Partnerships Committee	Risk Appetite and Tolerance	Open															
	Director	Chief People Officer	5Ts status	Treat															
	Date risk opened	02/04/26	Date of last review	02/09/26															
Target control date			31/03/27																
Controls				Gaps in Controls				Assurances				Gaps in Assurances							
- Our People Plan - Action plan in response to NHS Staff Satisfaction Survey results. - Team Engagement and Development (TED) Tool and toolkit to support team-level engagement and improvement - Single Improvement Plan. - Equality Impact Assessment policy. - NHSE 8 High Impact (EDI) Actions & NHS People Promise. - Culture programme, including Zero Tolerance campaigns. - Freedom to Speak Up Policy, Process and Champions. - Employee Relations policies and processes. - Trust Values/Best Version of Us/Leadership in Lancs frameworks. - Core People Management Skills programme. - Leaders/All Colleague briefings - Colleague engagement strategy and offer, including the Your Voice programme with structured leadership visibility - Compassionate Performance Conversations Training & Team level civility workshops - Use of Staff Survey data to support targeted bespoke OD support for lower performing teams				- Variation in local leadership capability and application of people management practices. - Capacity and time pressures on managers limiting their ability to consistently prioritise colleague engagement, people management and follow-through on actions. - System-wide operational and financial pressures limiting improvement in day-to-day experience. - Gap between staff feedback and visible action at team and divisional level. - Inconsistent senior leader visibility and engagement with colleagues				<u>Level 1 Assurance</u> - NHS Staff Survey reports including year-on-year analysis, corporate action planning and evaluation of targeted OD and engagement support. - Monthly reporting of TED participation and team-level engagement - Quarterly National Quarterly Pulse Survey reporting. <u>Level 2 Assurance</u> - Our People Plan Strategy Monitoring. - Single Improvement Plan reporting. - People and Partnerships Committee oversight and challenge <u>Level 3 Assurance</u> - External benchmarking through NHS Staff Survey comparator analysis and Workforce Equality Standards (WRES/WDES) reporting. - CQC inspection/Well-Led findings - NHSE/National Provider Improvement Programme				- Limited assurance that workforce initiatives and local actions are delivering measurable improvements in colleague experience and engagement. - Variable National Quarterly Pulse Survey response rates, limiting confidence in real-time workforce insight. - Limited availability of timely measures of colleague experience outside the annual NHS Staff Survey. - Challenges in demonstrating the reach and effectiveness of organisational communication and engagement channels.							
Risk Treatment																			
Action		Action Owner		Due Date		Done Date		Action Progress Update											
Increase use of TED to support team-level engagement, involvement and local action planning		S. Kenny		30.09.26 31.03.27				August 26: TED delivery has been strengthened through coaching and revised training arrangements. Completion levels continue to improve, with targeted divisional support, communications and inclusion within Matron and Ward Manager programmes helping drive uptake. Progress continues to be monitored against the annual target.											
Delivery of actions in NHS Staff Survey Action Plan for 2026/27		S. Kenny		31.03.27				August 26: Corporate and Divisional action plans have been agreed following review of NHS Staff Survey results. Monitoring arrangements are in place, and targeted Organisational Development (OD) support has commenced for priority teams. Impact will be evaluated following publication of the 2026 Staff Survey results.											
Strengthen senior leader visibility and engagement through structured programme of colleague engagement activity		S. Kenny		31.03.27				August 26: July Your Voice events were delivered successfully, and the refreshed Trust Values are progressing through approval ahead of relaunch. Recognition and local engagement activity continue, including an event led by the Chief Nursing Officer to celebrate high-performing teams and share learning.											
Strengthen managers' capability and confidence to hold compassionate, supportive and effective conversations throughout the employee lifecycle		S. Kenny		31.03.27				August 26: Delivery of the refreshed Leadership and Management Development Offer is underway. Core management, leadership, performance management and compassionate conversation programmes have been updated, with revised leadership frameworks due to launch in September 2026. Planning has also commenced for a Trustwide Leadership Conference in Feb 2027											

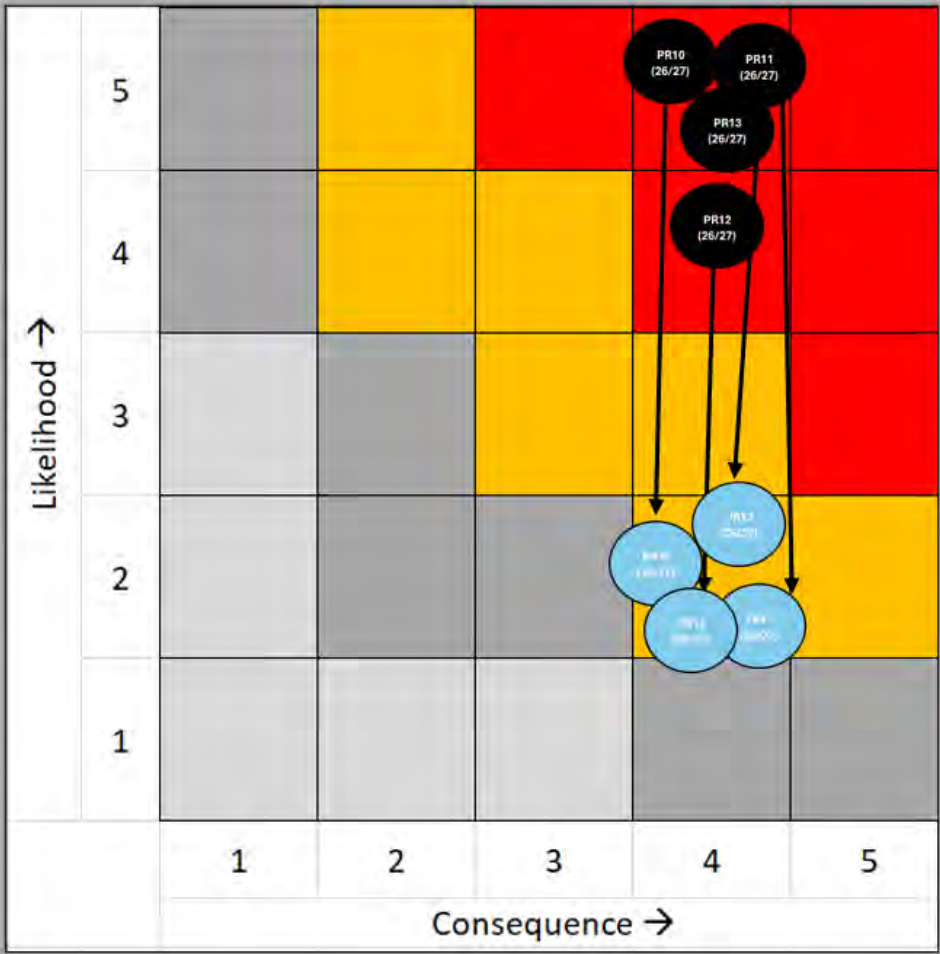
Strategic Objective: People						Corporate Objective: Support the health, wellbeing, safety and attendance of our workforce						Overall Assurance Level		Medium			
Principal risk 9 (26/27) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates										Risk Score Tracker  Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal					
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.															
	Committee	People and Partnerships Committee	Risk Appetite and Tolerance	Open	 Likelihood ↑ Consequence → ● Initial ● Current ● Target												
	Director	Chief People Officer	5Ts status	Treat													
Date risk opened	10/02/14	Date of last review	02/09/26														
		Target control date	31/03/26 30/09/26														
Controls				Gaps in Controls				Assurances				Gaps in Assurances					
- Sickness Absence Policy in place. - Core People Management Skills training in place. - Monthly reports to Divisions - check & challenge. - Accountability Framework in place which has recently been refreshed. - Toolkits and templates for Managers. "What Good Looks Like" for Managers. - Live data & reports in Health Roster. - Workforce Advisor Support in place (although at an insufficient level) - Health & Wellbeing Strategy in place. - Workforce & Organisational Development Strategy in place. - Operational processes in place Divisionally to look at staffing levels. - Dashboards in rosters to see safe staffing levels. - Rostering guidance and support in place.				- Gaps in localised management practices. - Lack of one complete absence record affecting ability to demonstrate policy compliance. - Insufficient capacity within the Workforce team to support absence management as proactively as possible. - Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. - Lack of triangulated data to support prediction/notice of warning signs for sickness absence. - Insufficient capacity within the psychological wellbeing service. - Development of mechanisms to prevent additional work/shifts which are counterintuitive to sickness absence position.				<u>Level 1 Assurance</u> - Divisional Workforce Committees. - Sickness absence reports are produced on a monthly basis which enables trend analysis of absence rates at cost centre level. These are reported through divisional workforce committees. - The Workforce team have undertaken local audits of absence management practice e.g. Return To Work Interview compliance. <u>Level 2 Assurance</u> - People and Partnerships Committee. - Divisional Improvement Forums review absence levels. <u>Level 3 Assurance</u> [None detailed]				- Currently a manual process to monitor compliance with absence management policy and processes. - Inability to achieve the 4% target. - Internal audit of sickness absence management practices, (October 2024) provided limited assurance.					
Risk Treatment																	
Action		Action Owner		Due Date		Done Date		Action Progress Update									
Pilot Empactis as a digital absence management system		R. O'Brien		31.07.26 31.08.26		31.08.26		August 2026: An alternative digital solution has been fully scoped, and the supplier has worked with us to develop solutions to issues identified with the Healthroster interface. A business case has been developed, and this will be reviewed by EMT on 9 th September and TMB on 16 th September. IT Governance is already underway. Once contracts are signed, the implementation period will be 3-months; however, the required procurement process is still to be clarified.									
Introduce Occupational Therapist into Occupational Health model		R. O'Brien		31.12.26				August 2026: The costs of the Occupational Health service have increased significantly in 2026/27, having remained static with no inflationary uplift for several years. We are working with Wellbeing Providers to explore how an Occupational Therapist could be introduced into the staffing model at no additional cost; however, this requires skill mix review and re-purposing vacancies, and further assurances are required that there will be no detrimental impact upon service delivery.									
Deliver absence reduction 'plan on a page' against 4 key workstreams		R. O'Brien		31.03.27				August 2026: Actions are progressing under the 4 workstreams.									
Implement new digital absence management system		R. O'Brien		31.03.27				New action									

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

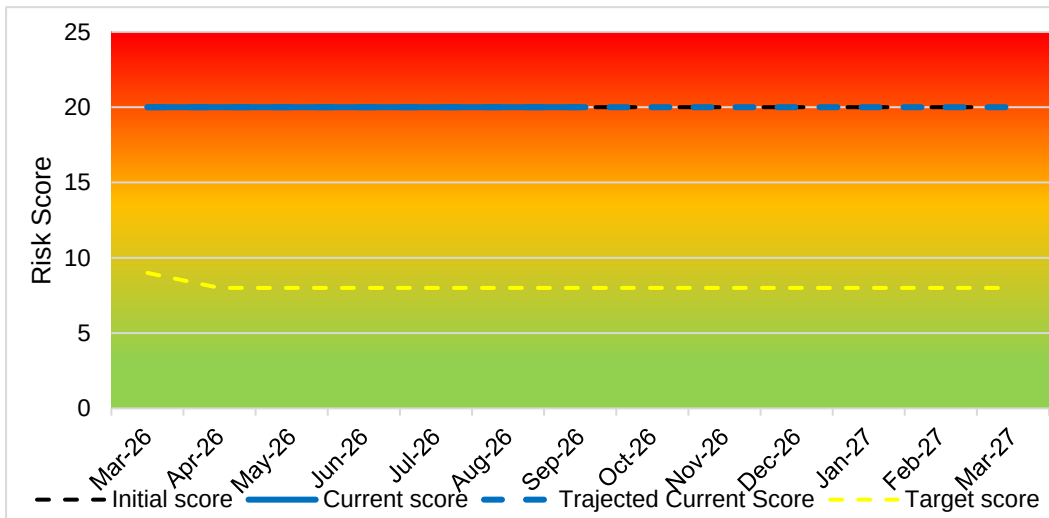
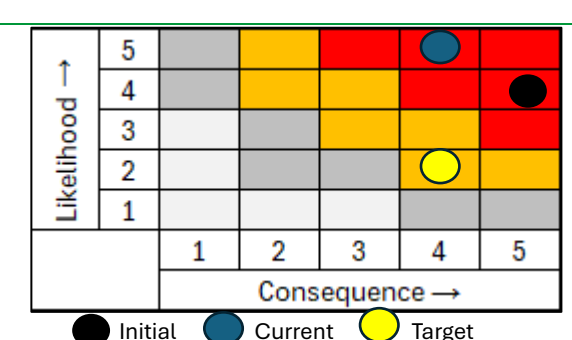
The following 2026/27 corporate objectives are aligned to the **Productivity** strategic objective

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
4.1	Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation	- Delivery of agreed Waste Reduction Plan - Consistent compliance with EQIA associated governance to ensure patient care is maintained.	- Teams delivering to the forecasted plans - Progress in the Improvement and Assurance group (IAG) exit criteria to progress towards exiting National Oversight Framework (NOF) 5	Risks identified
4.2	Increase Local Procurement	Prioritise sourcing goods and services from local suppliers, contributing to the economic stability, wealth and growth of the region.	- Number of active local suppliers used - Spend through collaborative arrangements (e.g., LPC) that includes explicit local social value or supplier development commitments	No risk identified
4.3	Expand use of telemedicine and Remote Monitoring	Expansion of telemedicine services to provide remote consultations and monitoring, ensuring patients have access to care regardless of their location	Increased ability to manage chronic conditions and reducing hospital admissions	No risk identified
4.4	Implement digital Patient Engagement Tools	Development of digital tools and platforms to enhance patient engagement, such as mobile apps for appointment scheduling, medication reminders, and health education	- Outpatient efficient metrics - Outpatient friends and family feedback metrics	No risk identified
4.5	Expand the use of AI and Machine Learning	Implementing AI and machine learning algorithms to enhance diagnostics, predict patient outcomes, and optimise treatment plans	More accurate and timely care, reducing the burden on healthcare professionals and improving patient experiences	No risk identified



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

Strategic Objective: Productivity		Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation				Overall Assurance Level		Low		
Principal risk 10 (26/27) (ID 1557)	Risk Title:	Delivery of the 2026/27 financial plan whilst reducing the size of the underlying financial deficit					Risk Score Tracker --- Initial score — Current score — Trajected Current score - - - Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)			
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2026/27 and reduce the underlying deficit. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, further regulatory intervention, impact on staff experience, and reputational damage.								
Committee	Finance & Performance	Risk Appetite and Tolerance	Open	Likelihood ↑ 5 4 3 2 1 1 2 3 4 5 Consequence → ● Initial ● Current ● Target						
Director	Chief Finance Officer	5Ts status	Treat							
Date risk opened	03/06/24	Date of last review	09/09/26							
		Target control date	31/03/27							
Controls		Gaps in Controls		Assurances			Gaps in Assurances			
- Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. - Financial plan triangulated with activity and workforce plans. - The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. - Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. - There are a suite of pay controls for filling vacancies and using agencies. - Processes are in place to ensure waste reduction programme (WRP) schemes that are delivered are transacted through the ledger. - There are a range of grip and control measures in place for managing discretionary expenditure. - There is a no PO no pay system in place for managing non pay expenditure. - Established Programme Management Office (PMO). - Action plan in place following MIAA Grip and Control Review. - Rebase of contract with commissioners to accommodate increasing demand and patient complexity.		Unavoidable cost pressures (industrial action and price volatility)		<u>Level 1 Assurance</u> - Ledger reconciliations - on the integrity of the financial data. - Variance and trend analysis - on the integrity of the financial data. - Grip & Control measures reported to Trust Management Board. <u>Level 2 Assurance</u> - Risks identified monthly to Finance and Performance committee. - Internal Audit - on the integrity of financial systems and variable pay processes - through Audit Committee. - Trust assessment of action in response to independent assessment of Grip and Control report by MIAA to be reported to Finance and Performance Committee. - Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. <u>Level 3 Assurance</u> - External Audit - on the financial accounts - through Audit Committee. - Collaborative working in ICS - integrity of financial data.			- Contracts not signed with commissioners, which creates uncertainty in relation to income. - Limitations and barriers work commissioned by the Recovery Support Programme (RSP) team not yet complete - Confidence in ability to deliver WRP plan			
Risk Treatment										
<u>Action</u>		<u>Action Owner</u>		<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>				
Fully developed WRP for 2026/27 and reported to Finance & Performance Committee		C. Carter		~~30.04.26~~ 31.07.26	31.07.26	Aug 26: A fully developed plan has been developed. Action to be closed				
Contracts to be signed no later than the end of Q1 2026/2027		C. Carter		~~30.06.26~~ 31.07.26	31.07.26	Aug 26: The ICB head contract was signed on 13/08/26. This action is now closed.				
Demonstrate progress with actions in delivery with WRP		C. Carter		31.03.27		Sep 26: Monthly Finance Recovery Board has now been introduced to review financial overspends and recovery actions at a broader organisational level to support weekly DDGs which monitory delivery of WRP programme at Divisional level.				

Strategic Objective: Productivity		Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation				Overall Assurance Level		Low		
Principal risk 11 (26/27) (ID 802)	Risk Title:	Cash consequences of the Trust’s underlying financial position					Risk Score Tracker 			
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.								
Committee	Finance & Performance	Risk Appetite and Tolerance	Open	 ● Initial ● Current ● Target						
			8-12							
Director	Chief Finance Officer	5Ts status	Treat							
Date risk opened	06/06/24	Date of last review	09/09/26							
		Target control date	31/03/27							
Controls		Gaps in Controls			Assurances			Gaps in Assurances		
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts. • Weekly system partners debtors update sent to CFO & DCFO • Prepayment arrangements in place for LTH hosted services		• Lack of full compliance with “No PO, No Purchase” arrangements • Access to cash support is subject to external approval.			<u>Level 1 Assurance</u> • Monitoring and reporting performance against 30-day deadline for payments. • Monthly Cash Review Group with CEO <u>Level 2 Assurance</u> • Internal Audit reporting through Audit Committee. • Monthly reporting of position including KPIs to Finance & Performance Committee. <u>Level 3 Assurance</u> [None detailed]			• Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. • Confidence in ability to deliver WRP plan		
Risk Treatment										
<u>Action</u>		<u>Action Owner</u>		<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>				
Strengthen system-wide cash management and financial resilience arrangements		C. Carter		31.03.27		Sep 26: System Deputy Directors of Finance are working collaboratively across partner organisations to identify and recover outstanding income and improve cash flow resilience. Ongoing mutual support arrangements remain in place to strengthen financial oversight and cash management.				

Strategic Objective: Productivity							Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation										Overall Assurance Level			Medium																																								
Principal risk 12 (26/27) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate										Risk Score Tracker --- Initial score — Current score — Trajected Current score --- Target score Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Trajectories and target reset for 26-27)																																																
	Risk Description:	There is a risk that there may be insufficient capital funding to support all priority areas of the Trust’s ageing estate. This is capital funding allocations are linked to the Trust’s underlying financial position, competing priorities across the healthcare system, and delays in approvals for nationally funded capital projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.																																																										
Committee	Finance & Performance		Risk Appetite and Tolerance		Open		Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target												5							4					●	●	3							2					●		1									1	2	3	4	5
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Controls					Gaps in Controls					Assurances					Gaps in Assurances																																													
- Trust planning framework. - Capital Planning Forum review and determine risk-based approach and recommendations. - Capital Plan for 2026/27 agreed by Executive Team & Trust Board. - Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. - Medical Equipment Group with clinical input to support risk assessment and prioritisation. - IT provided with a budget from Capital Planning forum. - Contingency budget identified at the start of the financial year. - Emergency capital funding process for extreme situations. - Receipt of significant national capital funding - Standing financial instructions. - Standing Orders. - Scheme of Reservation and Delegation. - Estates Strategy. - External funding for key developments approved. - Estates and Facilities Partnership Board established					- Short timeframes for external bids alongside limited operational capacity reducing ability to fully cost proposals. - Impact of inflation in terms of project costs and timescales. - Ageing estate and inability to comply with latest statutory guidance.					<u>Level 1 Assurance</u> - Tracking of project spend in Capital Planning Forum. <u>Level 2 Assurance</u> - Medical Device report to Safety & Quality Committee. - Capital update to Finance & Performance Committee. <u>Level 3 Assurance</u> 6 facet survey and independent annual report which details the scope and level of the situation. - Estates Returns Information Collection (ERIC) returns to support benchmarking.					- Significant backlog maintenance. - Governance around contract change notices. - Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind). - Confirmation of a long-term funding plan to support full delivery of backlog maintenance and critical infrastructure																																													
Risk Treatment																																																												
Action			Action Owner		Due Date		Done Date		Action Progress Update																																																			
Agree a fully worked up prioritised plan following confirmation all externally funded schemes			S. Ashworth		31.07.26 31.08.26		31.08.26		Aug 26: A full costed 3-year prioritised plan has been developed and is currently going proceeding through the trusts internal governance route and being shared with NHSE colleague to support funding approval.																																																			
Secure funding to support fully prioritised estates plan			S. Ashworth		31.03.27				Sep 26: Fully prioritised estates plan shared with NHSE colleagues. Awaiting response.																																																			

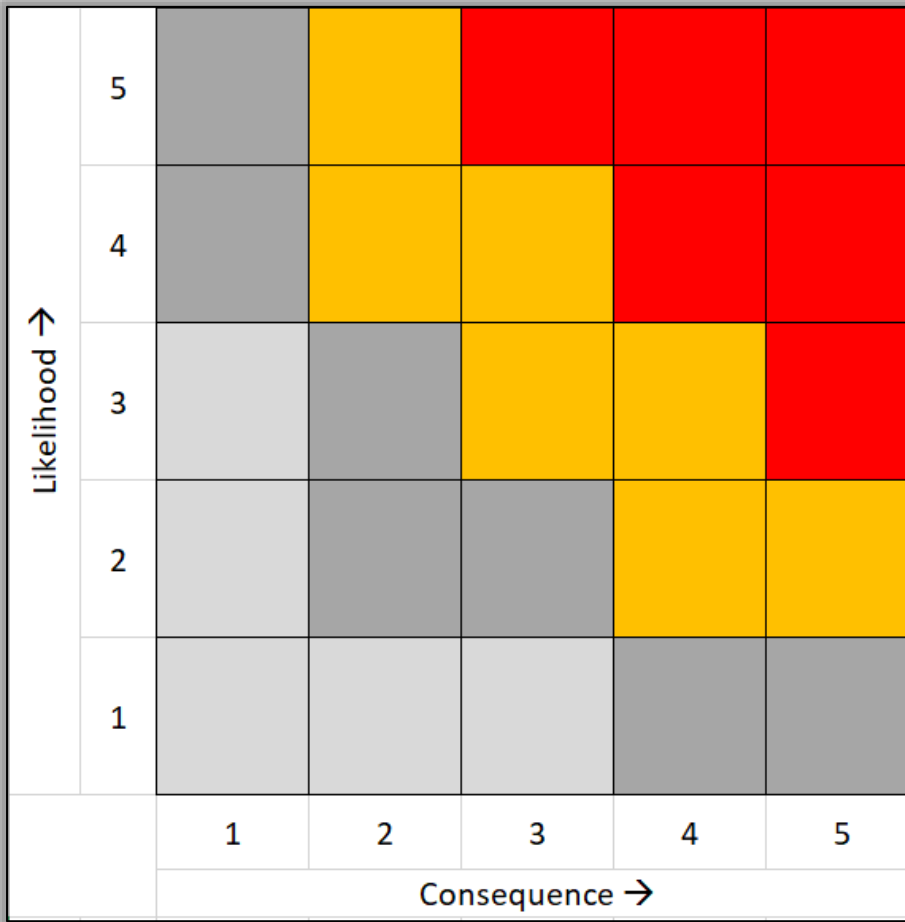
Strategic Objective: Productivity		Corporate Objective: Deliver the waste reduction programme without compromising quality or safety, including clinical pathway redesign, workforce optimisation, and digital innovation				Overall Assurance Level		Low																																												
Principal risk 13 (26/27) (ID 2318)	Risk Title:	Delivery of the planned reduction in whole time equivalent workforce					Risk Score Tracker Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal (Note: Initial score is same as current score and so not showing on graph)																																													
	Risk Description:	There is a risk that the Trust may not achieve the planned reduction in whole time equivalent (WTE) workforce for 2026/27. This is because of the requirement to increase performance, continued urgent and emergency care pressures and increasing patient acuity requiring workforce to be maintained or grow. This could result in an inability to achieve the waste reduction programme, inability to exit NHS Oversight Framework (NOF) segment 5 and further regulatory intervention.																																																		
Committee	Finance & Performance	Risk Appetite and Tolerance	Open	Likelihood ↑ <table><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td>●</td><td>●</td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td>●</td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table> Consequence → ● Initial ● Current ● Target							5							4					●	●	3							2					●		1									1	2	3	4	5
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		Target control date	31/03/27																																																	
Controls		Gaps in Controls			Assurances			Gaps in Assurances																																												
- Trust planning framework. - Medium term planning submission to NHS England. - Workforce plan triangulated with activity and financial plans. - Recruitment controls in place, including Vacancy Control Panel and EQIA process to support workforce decisions. - Business Case Process to fully and accurately assess WTE impact for transformational schemes. - WTE assumptions validated through PID approval with senior workforce sign-off - WRP WTE changes transacted through the financial ledger, ensuring alignment between workforce delivery and financial reporting - Integrated governance and reporting framework in place, providing oversight of WTE performance through PMO, DDGs, FPC, Executive Team. - Real time Daily Management System (DMS) dashboards for review of premium WTE usage by area (WLI/EDP/Bank and Agency). - Daily variable pay control group to control use and associate rates. - Twice daily safe staffing oversight meetings		- Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand, increased complexity and length of stay specifically patient Not Meeting Criteria to Reside (NMC2R) - Gap in funding for any MARS schemes to support reductions in the size of the workforce. - Operational pressures limiting management capacity to deliver schemes. - Activity plan demands driving requirement for additional WTE to support delivery. - Analyst capacity and skill in workforce information to provide level of assurance reporting required.			<u>Level 1 Assurance</u> - Grip & Control measures reported to Trust Management Board. <u>Level 2 Assurance</u> - Monthly NHSE Provider Workforce Returns (PWR) submission for monitoring of PWR effecting WTE delivery against plan. - Improvement and Assurance Group (IAG) and Waste Reduction Programme (WRP) Update to Workforce Committee. - PMO WRP reporting and WTE reporting into Finance and Performance Committee including WTE delivery and risk. <u>Level 3 Assurance</u> [None]			- The planned reduction in whole time equivalent workforce was not met for 2025/26. - WTE identified with PIDs is reliant on delivery of schemes, some of which are considered high risk. - There are schemes that will result in an improved run rate, however, may not reduce WTE, the ability to explain and demonstrate this is critical. - Workforce information capability and capacity is limiting progress on reliability of analysis and reporting.																																												
Risk Treatment																																																				
Action		Action Owner	Due Date	Done Date	Action Progress Update																																															
Deliver workforce reductions through the Mutually Agreed Resignation Scheme (MARS) and other agreed workforce reduction measures.		N. Pease	30.09.26	15.09.26	Sep 26: MARS Scheme 1 has been implemented, and MARS Scheme 2 has been launched. Delivery of the scheme is now business as usual, and benefits realisation will be monitored through a new action.																																															
Confirm the outputs and benefits realised from the workforce reduction scheme.		N. Pease	30.11.26		Sep 26: New action. Work is now focused on validating the workforce reductions delivered and confirming the financial and workforce benefits realised against plan.																																															
Deliver an overall reduction of worked WTE whilst maintaining safety in each professional group as a result of recruiting to substantive positions, reducing sickness and increased grip and control of health roster.		S. Morrison / S. Canty	31.08.26 30.11.26		Sep 26: The CFO and CPO are working together to establish reporting arrangements that provide a clear understanding of the worked establishment position and associated workforce metrics.																																															
Define One LSC recruitment metrics to manage recruitment delays and monitor emerging workforce risks.		N. Pease	30.11.26		Sep 26: New action. Recruitment delays have been identified as an emerging risk. Work is underway to define recruitment metrics and reporting arrangements to support improved oversight and management of recruitment.																																															
Identify priority workforce transformation programmes and track through SIP.		N. Pease	31.08.26	15.09.26	Sep 26: Priority workforce transformation workstreams have now been identified as: non-medical job planning, fragile services/long-term vacancy areas, medical recruitment and healthcare assistant recruitment. Reporting on these workstreams will be incorporated into enhanced transformation reporting through FPC.																																															
Delivery the analogue to digital programme. a) PEP + b) Self check in c) Ambient Voice Technology		A.Brotherton	31.03.27	15.09.26	Sep 26: Increased programme oversight has resulted in the establishment of the Digital Partnership Board. The programme will now be monitored through enhanced transformation reporting through FPC.																																															
Delivery of premium staffing cost scheme.		N. Pease	30.10.26		Sep 26: A cohort of premium staffing expenditure has been identified and is being systematically reviewed to reduce spend and support delivery of the workforce reduction programme.																																															

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2026/27 corporate objectives are aligned to the **Partnership** strategic objective:

CO Ref.	Purpose of the objective	Scope and Focus of the Objective	How will we know if it has been achieved?	Status
5.1	Be a collaborative system partner	Working with partners across Lancashire and South Cumbria to prevent ill-health, reduce health inequalities and work across organisational boundaries to develop integrated services across primary, community, and secondary care	- Delivery of provider collaborative priority clinical transformation schemes - Delivery of phase two Pathology single service objectivesTeams delivering to the forecasted plans	No Risks identified
5.2	Implement the Integrated Care System-wide diagnostics strategy, including unified PACS/RIS and cardiology systems	Standardising Picture Archiving and Communication Systems (PACS), Radiology Information Systems (RIS), and cardiology platforms across organisations to ensure interoperability, reduce duplication, and improve the flow of information between providers	- More coordinated care pathways - Improved access to diagnostic results - Enhanced the ability to share expertise across sites	No Risks identified
5.3	Implement a unified Laboratory Information System across the ICS	- To enhance diagnostic efficiency, data sharing, and clinical decision-making - Streamlining of laboratory workflows, reduced duplication, and enable real-time access to test results across multiple care settings	- Faster turnaround times - Improved accuracy - Better co-ordination between primary, secondary and community care providers	No Risks identified
5.4	Further develop our partnerships in Education	- Enhance the learning and development of our people and future healthcare professionals - Collaboration with leading universities, colleges, and training institutions placements, and research opportunities, ensuring that our people and students are equipped with the knowledge and skills needed to excel in their roles	- Provision of comprehensive educational opportunities fit for future healthcare education - Further development of a culture of continuous learning and innovation, ultimately improving patient care and outcomes	No Risks identified
5.5	Improve research and innovation	- Investment in research initiatives and partnerships with leading academic institutions ensures that we stay at the forefront of advances in research - We will further build our partnerships with industry to optimise supporting commercial research	Improvement in the offers our patients receive to access to the latest clinical trials and treatment.	No Risks identified
5.6	Vertical integration with community services, providing comprehensive pathways for Central Lancashire working with primary and social care	- Develop comprehensive, joined-up pathways that span prevention, diagnosis, treatment, and ongoing support - Vertical integration to ensure that patients experience continuity across different levels of care, from community to hospital - Strengthened collaboration between services operating at the same level	- Reduction in health inequalities, through a reduction in gaps in access, outcomes and experience - Improved management of long-term conditions (reduced emergency attendance and unpanned admissions - Shift from reactive to preventative care	No Risks identified



Heat map key: Black = current score, Blue = target score
Note: There are no Principal Risks aligned to Partnership currently

REFERENCES

Only PDFs are attached

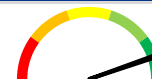


9.2 Winter Plan BAS Self Assessment Ancillary Board Pt I October 2026.pdf

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	4 - Substantial assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	4 - Substantial assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Provider/Trust Name (drop down):

Lancashire Teaching Hospitals Foundation Trust

If Other, write Provider/Trust Name:

Contact details (email, phone number):

Laura Walsh - laura.walsh@lthtr.nhs.uk

Date:

26/08/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	No	Winter plan developed and due to be signed off Oct Board	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	No	EQIA completed but awaiting board review - Oct	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Winter plan developed with system partners and reviewed/monitored via the system operational delivery group	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Regional winter led event, lessons learnt from 25/26 completed May 26 and incorporated into the winter plan for 26/27	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	In place - Katie Foster-Greenwood (COO)	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Embedded site management team. Site pressure score process to inform position and escalation using opel framework which includes clear actions and identification of roles and responsibilities	

			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	The Flu vaccination programme will be delivered via a peer vaccination model with staff identified to support and training provided where required. The vaccination scheme will cover all working shifts to enable staff to attend, it will be delivered within the workplace setting on a drop in or appointment based service.All vaccinations will be recorded on both RAVS & ESR	We have sufficient funding to run a vaccination campaign until 31 December 2026, with
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Vaccination uptake data is monitored weekly at team level enabling targeted response to increase uptake. A detailed 12 month Health and Wellbeing plan for the organisation is in place, which includes broader	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Policy and process in place	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Current process's in place to identify vulnerable and/or high risk patients. These cohorts are regularly monitored by clinical and safeguarding teams to ensure that th	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	This is an ongoing piece of work. Work completed, embedded and ongoing with LA partners in relation to social care support. Ongoing review of pathways ongoing t	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Embedded surge response planning in place as BAU - As part of the system	approach to winter planning, a number of funded schemes are being approved to supp
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	This is in place and BAU for winter for pre and post Christmas holiday periods. See 2.1 for further information	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	EMAC & MDU now in place with optimised pathways	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Frailty pathways reviewed as part of a national frailty workstream with LSCFT	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Safer staffing levels are established in all clinical areas with healthroster as the tool to manage and predict shortfalls. Matron of the day role in each division to man	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Rotas reviwed and in place. Job planning completed. Escalation process via	hospital site team in relation to shortfalls due to sickness with a process to ensure that t
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Control room in place to monitor all planned activity including cancer as well as diagnostic capacity. The control room reports into the weekly Operational Performan	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Performance trajectories in place and monitored closely via a weekly operational board	with monthly review via FPC committee
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	No	PARTIAL - hospital at home capacity available over the winter period. Community capacity currently under review with LSCFT as the provider of 2UCR however co	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	There is a policy and process in place to manage (and escalate) patients in boarded areas including corridors. The implementation of the emac & MDU is integral to	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	There is an ambulance handover policy in place which includes action cards and a clear escalation route for crews that are unable to handover patients. This is mon	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	We have shared our escalation policy with partners and have tested this recently during times of operational pressure which has resulted in positive outcomes. Site	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	The UEC improvement program includes model ED requirements and GIRFT recommended pathways	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	No	Partial - Side room capacity will be a challenge during the winter period when	The trust position is that there is partial assurance. The main inpatient wards in medicine are located within aging estate, there is a risk on the Trust Risk Register titled, "insufficient side room capacity to meet infection control requirements due periods of high operational pressure". The controls in place to mitigate this risk include: - Infection control policies including cohorting arrangements - Point of care and rapid testing procedures to quickly identify patients that need isolating and exclude those that do not - Daily review by the IPC team to step down patients out of isolation
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Deputy CNO has developed the response for this self assessment and actively monitors the IPC challenge	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	IPC is a madatory training requirement for all staff and sepsis training is mandatory for all clinical staff. We have comprehensive plocies and process's in relation to	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	In addition to 5.2 & 5.3, IPC attend daily site management meetings and support with decision making around flow. The site management meeting is part of internal	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Oncall arrangements in place and embedded - 24/7 management rota in place via the site team	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	This is via the site management team and our site pressure score which is refreshed every 15 minutes throughout the day. The site pressure score is linked to the n	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Mutual aid arrangements are in place where possible, planned care mutual aid is co-ordinated via the PCB with organisational Dep COO's	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	BCPs are in place for all services across the organisation. We are currently in the process of reviewing and tested a number of plans following an audit which identif	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	All severe weather & infrastructure contingencies have been reviewed by the EPRR team during September &	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	IA contingencies are in place and have been tested during periods of IA	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Management of staff via health roster allows for visibility of hours worked to ensure that adequate breaks are taking place. Visible Clinical Leadership across all divi	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Community services have a weeeekly sit rep in place which identifies areas of operational pressure. This allows the ADO and service managers to take necessary st	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Each CMHT has a morning huddle where high risk patients are discussed. This provides an MDT approach to managing complex patients in the community, and enr	

	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	The CMHT/RITT will continue to support assessments in the A&E department/136 suites for patients open to their service. MHLT will ensure they use extra staffing if
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Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Lancashire Teaching Hospitals

Provider CEO name: Silas Nicholls

Date reviewed: 01/10/2026 - trust board

Provider Chair name: Mike Thomas

Date reviewed: 01/10/2026 - trust board

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Katie Foster-Greenwood - Chief Operating Officer - katie.foster-greenwood@lthtr.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Confirmed - 26/08/2026

Please confirm date reviewed

26/08/2026

10.1 APPRAISAL, REVALIDATION AND MEDICAL GOVERNANCE (GMC)

ANNUAL REPORT

● Decision Item

REFERENCES

Only PDFs are attached

-  10.1a Appraisal, Revalidation and Medical Governance 2025-26 Annual Submission Ancillary Board Pt I Oct 2026.pdf

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **30 October 2026**

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Lancashire Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	Acute and elective NHS secondary and tertiary care services

	Name	Email
Responsible Officer	Mr Steve Canty	Steve.Canty@lthtr.nhs.uk
Medical Director	Mr Steve Canty	Steve.Canty@lthtr.nhs.uk
Medical Appraisal Lead	Dr John Anderton	John.anderton@lthtr.nhs.uk
Appraisal and Revalidation Manager	Debbie Kellett	Debbie.Kellett@LTHTR.nhs.uk
Head of Medical Workforce	Pauline North	Pauline.North@LTHTR.nhs.uk
Deputy CMO Professional Standards	Mr Eric Mutema	Eric.mutema@lthtr.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No

Yes

If yes, who is this with?

Organisation: St Catherines Hospice
Please describe arrangements for Responsible Officer to report to the Board: Act as RO for doctors employed by St Catherines Hospice
Date of last Responsible Officer Report to the Board: 15/10/2025
Action from last year: Continue with process for presentation of report to Board

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Lancashire Teaching Hospitals NHS Foundation

Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	Dr Skales is retiring in late 2025. Mr Steve Canty has been appointed as her successor
Comments:	Mr Steve Canty remains the Responsible Officer from October 2025
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	N															
Action from last year:	Continue to review and benchmark resourcing for Appraisal and Revalidation administration.															
Comments:	No change in funded time allocated. Due to the Trust's financial position, there has not been any change in resource allocated to revalidation and appraisal, despite the substantial increase in doctors since the introduction of the requirement to revalidate. The number of doctors connected to the Trust as their designated body has seen an increase year on year with no increase in provision of support for this. The doctors connected to the Trust were just over 400 in 2015 and currently there are nearly 900 professionals requiring appraisal with the same number of staff and resources afforded to support the Responsible Officer. Benchmarking against local Trusts also indicated provision of support for Responsible Officer functions to be the lowest in the area. In addition, The Revalidation & Appraisal Manager is involved in additional activities that are not expected of their peers. L&SC Trust comparison <table border="1"><thead><tr><th>Trust</th><th>Connections</th><th>Admin Staffing (WTE)</th></tr></thead><tbody><tr><td>BTH</td><td>~500</td><td>~1.7</td></tr><tr><td>ELHT</td><td>~750</td><td>~2.0</td></tr><tr><td>LTHTR</td><td>~850</td><td>~1.0</td></tr><tr><td>UHMB</td><td>~600</td><td>~2.2</td></tr></tbody></table>	Trust	Connections	Admin Staffing (WTE)	BTH	~500	~1.7	ELHT	~750	~2.0	LTHTR	~850	~1.0	UHMB	~600	~2.2
Trust	Connections	Admin Staffing (WTE)														
BTH	~500	~1.7														
ELHT	~750	~2.0														
LTHTR	~850	~1.0														
UHMB	~600	~2.2														

	Connected doctors	Admin Staffing (WTE)	
BTH	523	1.75 *	0.9 WTE Medical Workforce Operational Manager managing Medical Rostering, Appraisal and Revalidation, Bank and Temporary Staffing 1 WTE Medical Workforce Team Leader 0.5 Medical Staffing Administrator
ELHT	748	2	1 WTE Medical Appraisal & Revalidation Co-ordinator 1 WTE Medical Appraisal & Revalidation Administrator
LHTR	859	1	1 WTE Revalidation & Appraisal Manager
UHMB	621	2.14	0.64 WTE Medical Appraisal and Revalidation Manager 1 WTE Medical Appraisal and Revalidation Administrator 0.5 WTE Medical Appraisal and Revalidation Administrative Assistant
*Adjusted for Operational Manager covering several areas			
		The Revalidation & Appraisal Manager is single-handed which represents a significant risk for the Trust. This was demonstrated in September/October 2025 when the Revalidation & Appraisal Manager was absent for almost 4 weeks. During this time, medical appraisals did continue but there were no administrative tasks completed e.g. follow up of non-participants, appraisals reviewed and marked complete, management of starting and leaving doctors.	
Action for next year:		The Responsible Officer is working with the Head of Medical Workforce to review the current capacity and demand, balanced against the Trust's financial position, bearing in mind the risk of 'Single Point of Failure' with only one person managing the workload.	

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	None
Comments:	The Revalidation & Appraisal Manager (RAM) monitors new starters, leavers, and all GMC connections in line with agreed processes.
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	Update of policy to include Physician Assistants (PAs) and Physician Assistants in Anaesthesia (PAAs) in response to the introduction of a requirement for GMC registration of this staff group
Comments:	Policy update due in 2028. The review process has begun with consultation with key stakeholders and a draft policy is in draft.
Action for next year	Complete and publish new appraisal policy by the end of 2027

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	None
Comments:	Summary provided in 2024 report of outcome and actions completed following the last peer review in July 2023
Action for next year:	None

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Continue to ensure all bank doctors receive adequate support from the Appraisal & Revalidation team to ensure they meet the requirements of GMC revalidation. Set minimum clinical activity requirement to enable a doctor to have a prescribed connection to the trust.
Comments:	The trust has a well-established medical bank team. In October 2024, the Bank team was moved in-house resulting in a reduction in the number of doctors working via an Agency.

	Doctors engaged through the bank work ad-hoc hours, some more than others. Some bank doctors require the trust to act as their designated body when they undertake most of their work at Lancashire Teaching Hospitals whereas others may be employed elsewhere, and this employer acts as the designated body. For those with a prescribed connection to LTH as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust. For those doctors without a prescribed connection, support for revalidation is provided on a case-to-case basis (e.g. completed exit report). All new doctors, including bank doctors, who have a prescribed connection are invited to attend training sessions on appraisal and revalidation.
Action for next year	Continue to ensure all bank doctors receive adequate support from the Appraisal & Revalidation team to ensure they meet the requirements of GMC revalidation Continue to update processes and policies relating to Bank doctors to ensure Responsible Officer is sufficiently assured of safe practice.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Continue to include reference to Good Medical Practice in training and feedback
Comments:	Standards maintained Requirement for inclusion of letters of good standing for external practice is monitored robustly. A system has been introduced to ensure all doctors receive information relating to complaints (PALS) and reported incidents (Datix/Ulysses) prior to their appraisal month
Action for next year:	Continue to include reference to Good Medical Practice in training and feedback Strengthen the monitoring of compliance in relation to complaints and reported incidents, embedding the link with internal providers of data.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Continue to work with L2P to improve reporting
Comments:	The trust continues to issue a series of reminders to doctors when appraisals are not completed, and these escalate if action is not taken by the individual doctor to complete the appraisal. The reminders sent are as follows: L2P – Notifications that appraisal is due (8,4 & 2 weeks before appraisal month, day 1 of appraisal month and day 1 of month after appraisal month) RAM - sends reminders half-way through month before appraisal month, appraisal month and month after appraisal month before escalating to formal reminders. 1st reminder – sent one month and one week following end of appraisal month. MAL and appraiser included. MAL contacts doctor to meet. 2nd reminder – sent 1 month later. MAL, CD & appraiser included. 3rd reminder – Non engagement notification sent 1 month later. MAL, CD, DMD & Deputy CMO included. At this stage the Deputy CMO will ask to meet the doctor to understand the reasons for the appraisal not being completed and set a target completion date. The trust also enables doctors to submit a postponement form where they have identified a delay. These are considered by the appraisal team and then, if agreed, completion is monitored according to the postponement date set. Doctors with a prolonged period of absence e.g. parental leave and long-term sick leave may be classified as 'approved-missed appraisal' depending on the circumstances.
Action for next year:	Review of the escalation policy in line with NHSE revalidation document

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Update as required
Comments:	Policy goes through the Trust ratification process and is in line with GMC good practice domains
Action for next year:	Update as required.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Continue to review appraiser: appraisee ratios and undertake new appraiser training as required
Comments:	This remains a challenge to maintain though all appraisees have had an appraiser allocated During 2025-26 the trust had 173 trained appraisers for connected 859 doctors. A total of 14 new appraisers were trained and started appraising in the 2025-26 year. An additional 11 are expected to be trained for the 2026-27 year. However, 10 appraisers stepped down from the role by the end of 2024/25 and 11 by the end of 2025-26 meaning the number of appraisers available is not increasing in line with connected doctor numbers. Reasons for appraisers stepping down are retirement, leaving the Trust, health reasons, changes in workload.
Action for next year:	Review remuneration and system of appraiser case load allocation with the policy review.

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Y
Action from last year:	Appraiser update sessions to include items identified via QA process and by appraisers themselves
Comments:	All appraisers were invited to attend an update session and attendance recorded. Any appraisers not attending have been provided with resources from the sessions and have been advised attendance is expected in the next round of sessions. Content of the sessions to be delivered in the 2026 calendar year has been refreshed and includes items identified from previous QA process and requested by appraisers: a. Reminders of required (and not required) documentation b. Leadership & educational appraisers c. Feedback/QA d. Expectations for Resident Doctors and PA/PAA appraisals e. Appraiser- led discussion Performance review (Quality assurance) should be completed by the RAM/MAL for 20% of appraisals, with feedback being provided to individual appraisers. This was completed for all active appraisers for the 2025-26 year with 196 appraisals undertaken in the 2025-26 year reviewed using a scoring tool. This represents 24% of the appraisals undertaken within the 2024-25 year and meets the minimum recommended threshold. The feedback from appraisees is collated by L2P and is available for appraiser development.
Action for next year:	Continue to develop appraiser update sessions in line with changes to practice and guidance and appraiser requests

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Continue to refine QA processes
Comments:	The QA process was not changed in this year in order to allow for comparison with the previous year. Scores were RAG rated: Total score possible: 48 RED – 15 or below AMBER – 16 to 23 GREEN – 24 to 48 Green further subdivided into Satisfactory, Very Good and Excellent No appraisers were identified as RED The RAM collates all scores to allow comparison between years and aid identification of any appraisers requiring additional support or who may not be suitable for continuing in the role. All appraisers identified as AMBER in 2024/25 were supported by the MAL and all showed improvement in 2025-26. The number of appraisers identified as AMBER was reduced from 5 in 2024-5 to 2 in 2025-26. Those identified in 2025-26 are being supported by the MAL. Post appraisal Questionnaire (PAQ) summary reports are being provided from the L2P system for those appraisers who have received 3 or more completed feedback questionnaires from appraisees. All appraisers are provided with: - An email explaining the QA process and their scoring, including acknowledgement of high scorers and improvement - Information about the scores across all appraisers - A copy of their QA scoring tool with comments - A copy of their PAQ report as above - A certificate of acknowledgement indicating the number of appraisals undertaken

	All new appraisers have a minimum of 3 appraisals scored using the QA tool and were invited to meet with the MAL to review their scores, discuss their initial experiences and receive support. The RAM collates all feedback obtained through the annual quality assurance process and themes identified from this feedback are incorporated into the annual update sessions.
Action for next year:	Continue with QA processes

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue to work towards further reduction of deferrals due to non-completion of 360 Multi source feedback.
Comments:	127 recommendations were made to the GMC between 1 April 2025 and 30 March 2026. These were as follows: f. 117 Positive Recommendations g. 10 Deferrals h. 0 non-engagers. The proportion of deferral has almost halved compared to the 2024-25 year – from 14% to 8%. Of the ten deferred, all were due to insufficient evidence. Eight of which were due to interrupted practice such as long-term sickness, maternity leave or periods of no employment meaning there was insufficient appraisal evidence and/or 360 feedback. Four were due to 360 MSF not being completed and the remaining one due to the appraisal not being completed prior to the revalidation due date. Allocation of 360 feedback 2 years before revalidation is now normal practice and many doctors are “revalidation ready” well ahead of their due date. There are, however, still a number of doctors who complete the process within 2 weeks of their revalidation due date. The RAM monitors progress of the 360 feedback via system reporting for all doctors with increased scrutiny in the six months ahead of due dates. Monitoring and communication could be improved if additional resource was available.
Action for next year:	Continue refining processes and communications as resourcing allows.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the

doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	No further actions
Comments:	All doctors are informed of their revalidation recommendation prior to submission to the GMC. An action plan was previously in use for doctors who were deferred; this fell out of use when there was a gap in the Deputy CMO Professional Standard role.
Action for next year:	Reinstatement of action plan for doctors being deferred.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Complete benchmarking exercise by November 2025
Comments:	Effective clinical governance for doctors is delivered through robust systems of assurance, accountability and continuous improvement. This includes the use of Ulysses for incident reporting and learning, alongside Data from FTSU (Freedom to Speak Up) to identify and address concerns raised by staff. The Guardian of Safe Working provides additional oversight of doctors' working conditions, exception reporting and safe working practices. Clinical governance is further strengthened through the Audit Committee, Monthly Divisional Board meetings, and regular review of SUI indicators, including never events, ensuring that significant risks and incidents are identified, scrutinised and acted upon. The organisation also promotes benchmarking of clinical practice, including through the National Clinical Improvement Programme (NCIP) and National Joint Registry, as well as GIRFT (Getting It Right First Time), to compare outcomes, identify unwarranted variation and drive improvements in quality and efficiency. The role of Medical Examiners provides an additional layer of independent scrutiny of deaths, supporting learning, transparency and identification of opportunities to improve patient care. Together, these mechanisms demonstrate a strong culture of clinical governance in which doctors are supported to deliver safe, effective and continuously improving care.
Action for next year:	Expand use of NCIP reports for benchmarking practice.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
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Action from last year:	N/A
Comments:	Concerns relating to ongoing matters regarding conduct or performance of doctors are reviewed regularly at a monthly meeting. This ensures any ongoing matters are being address appropriately and timely. Membership of the group is: • Chief People Officer • Chief Medical Officer/Responsible Officer • Deputy Chief Medical Officer (Professional Standards Lead) • Head of Workforce Advice • Head of Medical Workforce • Revalidation and Appraisal Manager Regular meetings (fortnightly) take place between the Chief Medical Officer and Head of Workforce Advice to discuss any performance or conduct concerns and plan appropriate actions. Where concerns arise, the following process takes place ensuring appropriate escalation through the medical leadership structure: • When a concern is raised the Clinical Director (CD) undertaken an initial review and if needed will escalate to the Divisional Medical Director (DMD). • DMD will link with Workforce Business Partner or Head of Workforce Advice and arrange a case assessment meeting to review the concern. This meeting should take place as soon as possible, ideally within 1 or 2 days of the issue being raised. In preparation for this meeting any relevant facts should be gathered to support decision making. • If it is felt that a formal process is the appropriate route, then the DMD will need to escalate to the Chief Medical Officer (CMO), and a ROAG meeting will need to be convened. • Any serious concerns can be escalated directly to CMO. ROAG meetings take place as and when needed and include the CMO (or deputy) the CPO, the Head of Workforce Advice and the relevant Divisional Medical Director.

Action for next year:	N/A
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1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	N
Action from last year:	None
Comments:	A system has been introduced to ensure all doctors receive information relating to complaints (PALS) and reported incidents (Datix/Ulysses) prior to their appraisal month is now embedded. It was not possible to insist on inclusion of both reports in appraisal whilst the process was in development, however reference to complaints and incidents was monitored by the RAM
Action for next year:	Inclusion of reports in relation to both complaints and incidents to be considered mandatory and this to be communicated to all doctors and appraisers. Any appraisals where this information is missing to be “referred back” for update.

1D(iv) There is a process established for responding to concerns about a medical practitioner’s fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	None
Comments:	The Trust ‘Handling Concerns about Doctors & Dentists Conduct & Capability’ Policy details how concerns are responded to. All ongoing Conduct and Performance concerns are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer, Chief People Officer, Head of

	Workforce Advice and the Revalidation and Appraisal Manager. Regular meetings are also held with the NHS Resolution Practitioner Performance Advice (PPA) and the GMC ELA (Employer Liaison Advisor) to review active cases. As well as these planned meetings, urgent cases are discussed by a decision-making group (membership as above) and referred where necessary for PPA/GMC ELA advice.
Action for next year:	Handling Concerns about Doctors & Dentists Conduct & Capability Policy to be reviewed.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Annual report will be produced and presented to People and Performance Committee in accordance with the cycle of business.
Comments:	This information is presented to the People and Performance Committee annually. It forms part of the Employee Relations Activity paper. The 2025/2026 report was prepared by the Head of Workforce Advice according to the Committee Cycle of Business and was presented in the July 2026 committee meeting.
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	None
Comments:	A RO-to-RO transfer of information form is completed and sent to a new organisation as requested. For a doctor with concerns, the transfer of information document is prepared by the RO or DRO and provided to the new organisation and doctor. The RO will communicate directly with the new RO to discuss any concerns if necessary or discuss with the GMC ELA if there is no current new designated body

Action for next year:	None
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1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Y
Action from last year:	None
Comments:	Trust policies followed for example MHPS, Early resolution policy, Freedom to Speak up policy. Policies are quality impact assessed and are completed in consultation with staff side and in various forums.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	None
Comments:	Lancashire Teaching Hospitals has implemented the Ockenden Review's immediate and essential actions, with particular focus on listening to women and families, informed consent, fetal monitoring, management of complex pregnancies, multidisciplinary learning, and strengthened governance and assurance arrangements. These improvements have been delivered collaboratively across the Lancashire and South Cumbria maternity system with Maternity Voices Partnerships.
Action for next year:	Implementation of recommendations from Leng Review.

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	None
Comments:	The GMC is now regulating Physician Assistants (PAs) and Physician Assistants in Anaesthesia (PAA)s with GMC registration required by 13th December 2026. There are 10 PAs and 8 PAAs employed by the Trust; all are now included on L2P and will be having appraisals in line with GMC Good Medical Practice The RAM is responsible for ensuring appraisal processes are in place and the CMO will oversee any concerns raised relating to conduct and capability of individuals. It is anticipated the GMC will publish further information relating to revalidation of these staff groups.
Action for next year:	Implement guidance in relation to PAs & PAAs when published by the GMC.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	None
Comments:	All doctors recruited to the Trust (whether substantive, fixed term or bank) are subject to the same pre-employment checks as defined by NHS Employment Check Standards

	Each check when completed is recorded on the Trust recruitment system (TRAC). All documents are seen and verified in person and are scanned as evidence.
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	Implement the revised leadership and management development offer. Continue to implement the cultural improvement actions as detailed under Our People Plan.
Comments:	The cultural improvement work that has been completed in the last 12 months includes: • Direct reach out and offer of supportive intervention to teams which have score 5% below the Trust average for sexual safety questions in the NHS Staff Survey. • Roll out of compassionate performance conversations. • Delivery of workshop to clinical directors on managing extremely difficult behaviour. • Continued delivery of Team Culture Masterclasses, Active Bystander training, Civility Masterclasses and Compassionate Performance Conversations. • Enhanced support for leaders through coaching, with the roll out of Coaching Hub and training of over 30 accredited coaches from multi-disciplinary backgrounds. • Strengthened processes for raising concerns, including the development of a Culture Risk Protocol and a centralised log for whistleblowing and protected disclosures. • Completion on a number of culture reviews into clinical areas which have flagged through different sources as indicating there could be cultural challenges impacting on colleagues' satisfaction, team working and potentially patient care.
Action for next year:	To refresh Our People Plan, this will include setting out the strategic direction around strengthening a positive organisational culture.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	The future focus to ensure we continue to deliver the strategic aims, of the EDI Strategy includes: • An expanded focus on intersectional reporting of our workforce centred data to help us interrogate our data across other areas i.e. talent management, retention, performance management etc. in a more meaningful way. • Developing intelligence around our data collection capturing patient experience to ensure we hear from patient groups who have traditionally been hard to reach, including those who experience deprivation or other health inequalities. • To further increase educational opportunities to support colleague and leaders understanding of their role in enabling equality, diversity and inclusion as well as bringing about improvements in health inequalities. • To review process and approaches across the colleague lifecycle to understand how we can create more inclusive practices which support the recruitment, retention, staff satisfaction and career progression of colleagues with protected characteristics.
Comments:	All reports to the People and Partnerships Committee where appropriate include data breakdowns by protected characteristic. A strategic Health Inequalities Plan has been developed and launched, with the focus of work to support the Core 20+5 priorities. Work is underway to achieve bronze level of the North West BAME anti racist framework.
Action for next year:	Relaunch of Trust values with a strengthened focus on inclusion, professionalism and civility. Relaunch of Trust Leadership in Lancs behaviour framework which is aligned to NHS managers code and leadership expectations. With renewed focus on leaders' role in compassion, inclusion, setting behavioural standards in teams.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	Implement the actions from the FTSU strategic action plan.
Comments:	Recruitment of a full time FTSU Guardian has been completed. Development of new strategic focus for FTSU which includes how whistle blowers are risk assessed to try and mitigate and prevent any detrimental treatment. There is a Raising Concerns group, where themes from FTSU are triangulated with other data sources, as a way to understand issues, actions and identify lessons learnt. Recruitment to and refresh of the FTSU Champions network. Increased communications and awareness raising of FTSU service. Increased number of FTSU 'drop in surgeries' delivered in the last 12 months, taking FTSU to different teams and services.
Action for next year:	To progress the actions identified in the FTSU strategic plan.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	None
Comments:	Complaints regarding the appraisal process are addressed through the Trust early resolution policy (Grievance policy). This is documented in the current policy.

	Any complaints about MHPS process are managed through the MHPS process. Anyone involved in an MHPS process is provided with a Non-Executive Director who they can raise any concerns to, in relation to the management and handling of the process.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Y
Action from last year:	To include details in the report relating to the country of primary medical qualification.
Comments:	A full equality impact assessment is taken on an annual basis for those colleagues who have been involved in formal processes to understand if colleagues with protected characteristics are disproportionately referred for investigation due to capability or conduct concerns. This is reported to a Board level subcommittee – People and Partnership Committee.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Continued participation in networking events.
Comments:	The RAM, MAL, RO and DCMO have attended North West Responsible Officer Network meetings RAM has attended North West Managers Group meetings MAL attended Clinical Revalidation Lead Network meeting RAM and MAL attended annual appraiser update session for a neighbouring Trust

Action for next year:	Continued participation in networking events
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Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	859
Total number of appraisals completed	812
Total number of appraisals approved missed	26
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	127
Total number of late recommendations	0
Total number of positive recommendations	117
Total number of deferrals made	10
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	5
Total number of trained case managers	4
Total number of concerns received by the Responsible Officer ²	7
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	131
Median duration of concerns processes closed (working days) ³	94
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	293
Total number of new employment checks completed before commencement of employment	293
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld ⁴	Case still progressing through ET process.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

Significant progress has been made during 2025/26 in relation to appraisal, revalidation and professional standards processes. Key achievements include:

- A reduction in the proportion of GMC revalidation deferrals from 14% to 8%.
- Continued achievement of timely revalidation recommendations, with no late recommendations and no non-engagement referrals.
- Successful implementation and embedding of processes to provide doctors with information relating to complaints and incidents in advance of appraisal.
- Completion of quality assurance reviews on 24% of appraisals, exceeding the recommended minimum standard.
- Recruitment and training of 14 new appraisers, with a further 11 expected to commence appraiser training during 2026/27.
- Continued support for bank doctors and strengthening of processes relating to prescribed connections and revalidation requirements.
- Introduction of appraisal arrangements for Physician Associates and Physician Associates in Anaesthesia to prepare for GMC regulation.
- Ongoing participation in regional Responsible Officer, Medical Appraisal Lead and Revalidation networks to support benchmarking and continuous improvement.

Actions still outstanding

The following areas remain under development:

- Completion and ratification of the revised Medical Appraisal Policy.
- Further strengthening of the provision of appraisal information relating to complaints and incidents.
- Review of appraisal escalation processes in line with updated NHS England guidance.
- Reinstatement of action plans for doctors receiving deferred revalidation recommendations.
- Review of resource requirements to support appraisal and revalidation activity.
- Review of the Trust's Handling Concerns about Doctors and Dentists Conduct and Capability Policy.
- Review of appraiser remuneration and appraiser workload allocation arrangements.

- Completion of benchmarking activity relating to Responsible Officer support functions and governance arrangements.

Current issues

The most significant challenge continues to be capacity within the appraisal and revalidation function.

Despite substantial growth in the number of connected doctors, increasing from approximately 400 in 2015 to almost 900 in 2026, there has been no corresponding increase in dedicated staffing or resource. The Revalidation and Appraisal Manager remains a single-handed function, creating a significant single point of failure risk for the organisation.

This risk became evident during a period of absence during 2025 when appraisal administration activity was significantly impacted despite appraisals themselves continuing to take place.

A further challenge is maintaining adequate appraiser capacity. While new appraisers continue to be trained, a similar number are stepping down due to retirement, workload pressures, health reasons or leaving the organisation, limiting overall growth in appraiser numbers.

The Trust also continues to experience a small number of revalidation deferrals resulting from interrupted practice and late completion of supporting information immediately prior to revalidation dates.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Review appraisal and revalidation capacity and demand, including mitigation of single point of failure risks.
- Complete and publish the revised Medical Appraisal Policy.
- Review appraisal escalation processes in line with NHS England guidance.
- Strengthen the inclusion and monitoring of complaint and incident information within appraisal documentation.
- Continue to develop appraiser update sessions in line with changes to practice and guidance and appraiser requests.
- Maintain QA reviews of appraisals.
- Review appraiser remuneration and case allocation arrangements.
- Continue refining processes and communications in relation to 360 completion as resourcing allows.
- Reinstate structured action plans for doctors receiving deferred revalidation recommendations.
- Expand use of NCIP reports for benchmarking practice.
- Continue development of bank doctor governance arrangements.

- Review the Handling Concerns about Doctors and Dentists Conduct and Capability Policy.
- Implementation of recommendations from Leng Review.
- Implement forthcoming GMC guidance relating to Physician Associates and Physician Associates in Anaesthesia.
- Continue participation in regional and national appraisal, revalidation and Responsible Officer networks.
- Refresh organisational culture, leadership and professional standards programmes through delivery of the Trust's updated People Plan and Freedom to Speak Up strategy.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The Trust remains compliant with the requirements of the Responsible Officer Regulations and continues to demonstrate effective oversight of appraisal, revalidation and professional standards processes.

Performance during 2025/26 has been positive, with high appraisal completion rates, no late revalidation recommendations, no non-engagement referrals and a reduction in revalidation deferrals. Quality assurance arrangements remain robust and there is evidence of continuous improvement across appraisal, governance and professional standards processes.

However, increasing numbers of connected doctors, combined with static resource levels, present a growing operational and governance risk. Particular attention is required to address the current reliance on a single member of staff supporting appraisal and revalidation activity, whilst maintaining the quality and timeliness of services.

The Trust enters 2026/27 with clear priorities focused on strengthening resilience, updating policies, improving governance processes and supporting the introduction of new regulated professional groups. These developments will help ensure continued compliance, effective professional standards oversight and a positive culture that promotes patient safety, professional development and continuous improvement.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	
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Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

11.1 SAFETY AND QUALITY REPORTS FOR CONSIDERATION

11.1A A)?PERINATAL WORKFORCE REPORT

● Decision Item

REFERENCES

Only PDFs are attached



11.1a Perinatal Workforce Report Ancillary Board Pt I October 2026.pdf



Patients



Performance



People



Productivity



Partnerships

Perinatal Safe Staffing Report

(March-August 2026)



Executive Slide Set Summary

This report presents the findings of Lancashire Teaching Hospitals NHS Foundation Trust's second perinatal safe staffing review for 2026. The review triangulates workforce, quality, safety, patient experience and clinical effectiveness data to provide assurance regarding the adequacy, sustainability and effectiveness of staffing across maternity and perinatal services.

The report fulfils the requirements set out within the National Quality Board (NQB) guidance on safe staffing for maternity services (2018) and the NHS Resolution Maternity Incentive Scheme (MIS) Year 8. In line with requirements, the review provides assurance that robust and effective workforce planning arrangements are in place and reflects the MIS Year 8 expectation that workforce reviews consider the wider perinatal workforce in addition to midwifery staffing establishments. Safe and effective maternity care is dependent upon the contribution of the multidisciplinary team, and workforce planning must therefore encompass maternity, obstetric, anaesthetic, neonatal, nursing and allied health professional workforces to ensure services have the capacity, capability and resilience required to meet the needs of women, babies and families.

The review continues to be structured around the National Quality Board's key expectations for safe, sustainable and productive staffing within maternity services: Right Staff, Right Skills, and Right Place at the Right Time. In addition, local measures aligned to Monitor and Learn (7.0) are included within Slide 3 reflecting the importance of insight, involvement and inclusion in the delivery of safe perinatal care. These measures incorporate safety culture, multidisciplinary collaboration, workforce wellbeing, learning from experience and the active involvement of women and families in service development and improvement. Through this approach, the review provides a comprehensive assessment of workforce effectiveness across the maternity and wider perinatal service.

The Safety & Quality Committee is asked to:

1. Endorse the approval of the Perinatal Workforce report and associated action plans.
2. Scrutinise the outcomes for perinatal services, noting the Safety and Quality committee have reviewed in detail the contents of the report.
3. Note there are gaps in provision to meet AHP and psychology standards in Neonatal Unit and a review of the medical model is underway to seek to address the gap in the service.
4. Note the requirement to fund as planned year 2 of Birthrate plus and for this to be included as part of the budget setting process.
5. Accept, in line with NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer and Chief Medical Officer confirm that they are satisfied with the outcome of the annual safe staffing assessment and that, while risks remain that require active management, approved staffing levels approved (with the addition of the 2 additional obstetricians) are considered safe, effective and sustainable.

National Quality Board's expectations for safe, sustainable, and productive staffing (2016) adapted for maternity settings



Right Staff (4.0)

Ensuring the right workforce is available



Evidence-based workforce planning every 6 months



Annual and midpoint reviews
Using Birthrate Plus® (BR+)



Informed by:

- Activity
- Acuity
- Complexity
- Red Flag data
- Safety intelligence



Appropriate:

- Skill mix
- Competence
- Experience
- Professional judgement



Recruitment and retention initiatives to support sustainability



Governance oversight to identify, mitigate and escalate staffing risks



Right Skills (5.0)

Developing a skilled and capable workforce



Multi-professional mandatory training, education and development



Aligned with:

- Ockenden Report
- Core Competency Framework
- National maternity safety priorities



Focus on:

- Clinical competence
- Human factors
- Leadership
- Communication
- Escalation
- Teamworking



Strengthening collaborative multi-professional working



Recruitment, retention, career development and succession planning



Resilient workforce for current and future service demands



Right Place, Right Time (6.0)

Deploying staff where they are needed most



Productive and efficient working practices



Flexible workforce deployment



Robust escalation processes



Real-time staffing decisions based on:

- Acuity
- Dependency
- Clinical risk



Resources directed to areas of greatest need



Aligned to:

- National maternity priorities
- Safe staffing principles
- Organisational objectives



High-quality care across all maternity settings



Monitor & Learn (7.0)

Driving continuous improvement and safety



Insight, involvement and inclusion



Regular monitoring of:

- Workforce metrics
- Quality indicators
- Safety performance



Perinatal Quality Surveillance Model (PQSM)



Identifying:

- Emerging risks
- Trends
- Improvement opportunities



Positive safety culture through multidisciplinary collaboration



Listening to women, families and staff



Co-producing service improvements to enhance:

- Safety
- Experience
- Outcomes

Evidence based workforce planning

A planned safe staffing review is undertaken by the Chief Nursing Officer, Divisional Midwifery and Nursing Director, Finance Business Partner and Midwifery Matrons every 12 months, with a further desk top review at 6-monthly intervals.

This provides assurance that a structured triangulation of professional judgement, perinatal safety indicators, patient acuity, service demand, and workforce trend data is undertaken. Seasonal variation, service developments, commissioning requirements, and workforce availability are explicitly considered, ensuring staffing establishments remain safe and responsive, with clear governance and escalation where risks are identified.

Birthrate Plus® continues to be utilised by the service alongside professional judgement and local intelligence for robust workforce planning every 3 years. The last review took place in 2025 with the report being published in October 2025. The findings of this report which confirmed that the staffing establishment was below the recommended safe staffing benchmark, was shared with the Trust Board in the last Safe Staffing report. As a result of this the Trust Board approved investment into the midwifery workforce over a 2 year phased plan with the majority of the funding being made available in the 2006/27 financial year. The plan and progress against this investment can be seen on slide 5.

An independent review of the Birthrate Plus® midwifery workforce planning methodology, published February 2026, confirmed that the tool remains credible for setting safe midwifery establishments. In the future, it is expected that further targeted updates (to reflect rising acuity, social complexity, and non-clinical workload) and stronger transparency/reporting will be added.

Recent published guidance relating to triage standards will affect the review outcome and any changes will be updated as the requirements and impact of this are more clearly understood.

1 Year 1 – Birth Rate Plus

 2025–2026

 Post	 Grade	 WTE	 Status Update
Specialist (Recruited to Date)			
Teenage Pregnancy and Safeguarding	Band 6	2.00	 Recruited to substantive posts
Bereavement Midwife	Band 6	0.60	 Recruited to substantive post
Fetal Medicine	Band 6	0.60	 Recruited to substantive post
Divisional Governance Lead for Maternity and Neonatal Services	Band 8a	1.00	 Recruited to substantive post
 Year 1 Total (Specialist)		4.20 WTE	
Additional Year 1 (Recruitment in Progress)			
Telephone Triage	Band 6	5.51	 Recruitment in progress, interviews 30 September 2026
Day Unit	Band 6	1.00	 Recruitment in progress
 Year 1 Additional Total		6.51 WTE	
 Year 1 Total		10.71 WTE	

2 Year 2 – Birth Rate Plus

 2026–2027

 Post	 Grade	 WTE	 Status Update
Specialist (Planned Recruitment)			
Deputy Specialist Midwife Public Health	Band 6	1.00	 Planned recruitment January 2027
Deputy Specialist Midwife Infant Feeding	Band 6	0.80	 Planned recruitment January 2027
Maternity Equity and Inclusion Midwife	Band 6	0.65	 Planned recruitment January 2027
Midwifery Teams	Band 6	2.09	 Planned recruitment January 2027
 Year 2 Total		4.54 WTE	

Executive Summary



Recruited to Date

4.20 WTE


Recruitment in Progress

6.51 WTE


Planned Year 2 Recruitment

4.54 WTE


Total Investment

15.25 WTE

Fill Rate Data Midwifery and MSW Staffing Levels (March- August 2026)

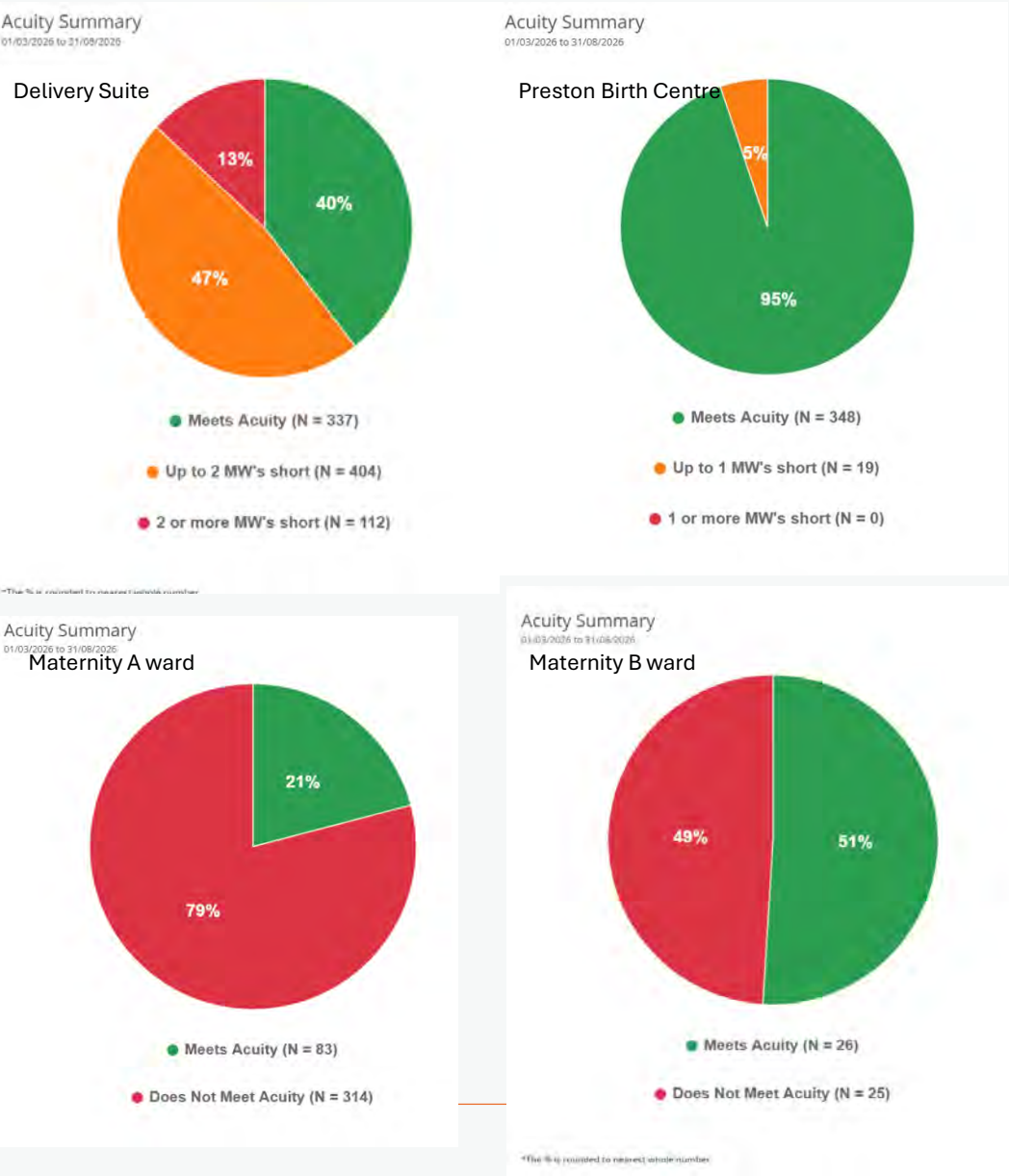
	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Registered Midwife (Day)	97%	98%	101%	98%	92%	90%
Registered Midwife (Night)	94%	97%	94%	96%	90%	87%
Midwifery Support Worker (Day)	77%	80%	89%	86%	82%	85%
Midwifery Support Worker (Night)	90%	97%	96%	92%	83%	95%

Fill rates are monitored closely by the service and reported to the Trust Safety and Quality Committee on a monthly basis. The fill rates have remained relatively stable with the reduction in July and August 2026 which is being driven by increased sickness levels within the service. An agency request has been submitted to ensure all reasonable steps are being taken to respond to the reduction in fill rates.

Sickness rates for the Specialty Business Unit of Maternity						
	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Absence FTE%	5.79%	5.00%	4.57%	7.23%	9.32%	8.28%

Following an improvement in sickness absence during the first quarter, rates have increased between June and August 2026, peaking at 9.32% in July 2026 before reducing slightly to 8.28% in August 2026. Workforce pressures continue to be mitigated through robust staffing escalation processes, effective use of temporary staffing, and deployment of Specialist Midwives and Area Managers where service acuity requires, ensuring safe staffing levels are maintained across maternity services. Long-term sickness absence cases continue to be managed in line with Trust policy and attendance management processes, with regular oversight provided by Matrons in partnership with Workforce colleagues to support staff wellbeing, facilitate timely interventions and ensure appropriate case management.

5. Birth Rate Plus Live Acuity Tool



Acuity levels within the service are collected using the Birth Rate Plus Acuity Tool. Information is inputted into the tool by the areas leads and this is used to inform daily staff redeployment and escalation. Data is collected for four areas of the service, these being Delivery Suite, Preston Birth Centre, Maternity Ward A, and Maternity Ward B.

The chart on this slide shows the acuity overview between 1st March 2026 through to 31st August 2026 for each of these four areas. Green is where staffing meets the acuity within the service, orange is where there is up to 1 midwife short in Preston Birth Centre and up to 2 midwives short on Delivery Suite. Red signifies there was 1 or more midwives short on Preston Birth Centre or 2 or more midwives short on the Delivery Suite. The ward areas are categorised with either a green, where the staffing levels are sufficient for the acuity, or red, where the staffing levels are not sufficient for the acuity.

It is evident that there have regularly been staffing pressures within Delivery Suite and on the ward areas. This information can be pulled on a daily basis and where acuity is exceeding the workforce in an area staff are redeployed from other areas and the escalation policy is initiated.

Slides 8,9,10 and 11 show a breakdown of reasons for the acuity gradings over this six month period for each of the clinical areas.

Slide 12 shows the categorisation of cases seen on the Delivery Suite over the six month period. From this information it can be seen that the majority of cases seen within the Delivery Suite are Grade Category IV (32%) or Category V (28%). These are the highest complexity category gradings and indicate the most intensive support requirements. This reflect the findings of the last Birth Rate plus assessment.

In addition to the daily mitigation in place the service has been undertaking a review of its staffing models to try to ensure that the service meets the demand and improves flow. A data review has been undertaken which has been triangulated with the birth Rate plus report and new national information. This will look at increasing staffing levels on Maternity A ward, and further stabilising the workforce on Maternity B ward and Delivery Suite. This review will be completed and implementation will have commenced by the end of December 2026

5. Birth Rate Plus Live Acuity Tool

Delivery Suite

Refer to slide 7 for analysis if the data

Number of Staffing Factors
01/03/2026 to 31/08/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	184	16%
SF2	Unable to fill vacant shifts	207	18%
SF3	Midwife on transfer duties	4	0%
SF4	MW redeployed to other area	33	3%
SF5	Support staff less than rostered numbers	23	2%
SF6	Continuity Midwife present	191	17%
SF7	Continuity Midwife unavailable	236	21%
SF8	No support staff available	45	4%
SF9	MW having to provide HDU care	194	17%
SF10	No cover for ELCS prep	4	0%
SF11	Consultant present at ward round	1	0%
SF12	Consultant not present at ward round	3	0%
SF13	Consultant present during escalation	4	0%
SF14	Consultant NOT present during escalation	4	0%
TOTAL		1133	

*The % is rounded to nearest whole number

Staffing Factors
01/03/2026 to 31/08/2026



Analysis: Delivery Suite recorded 1,133 staffing factors in six months, by far the highest of any area. Pressure is driven by continuity midwives unavailable (21%), unfilled vacant shifts (18%), unexpected absence (16%) and midwives providing HDU care (17%) - a unit routinely short-staffed and covering gaps by moving midwives from planned care. Consultant-related factors were rare, so the pressure sits with midwifery rather than medical cover.

Preston Birth Centre

Refer to slide 7 for analysis if the data

Number of Staffing Factors

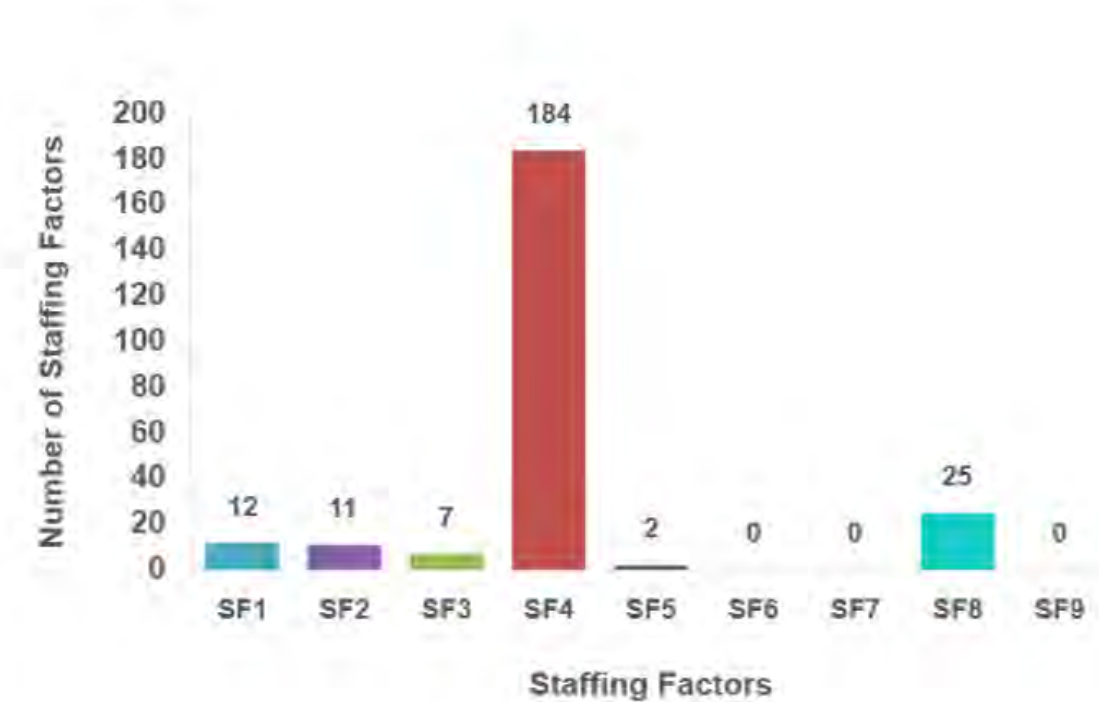
01/03/2026 to 31/08/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	12	5%
SF2	Unable to fill vacant shifts	11	5%
SF3	Midwife on transfer duties	7	3%
SF4	MW redeployed to other area	184	76%
SF5	Support staff less than rostered numbers	2	1%
SF6	Continuity Midwife present	0	0%
SF7	Continuity Midwife unavailable	0	0%
SF8	No support staff available	25	10%
SF9	No admin staff	0	0%
TOTAL		241	

*The % is rounded to nearest whole number

Staffing Factors

01/03/2026 to 31/08/2026



Analysis: The Birth Centre recorded 241 staffing factors, and 76% of them were midwives redeployed to another area. Its own absence (5%) and vacancy (5%) levels are low, so the centre is mainly acting as a source of cover for busier areas rather than being short itself. The next largest factor is no support staff available (10%). The risk is to continuity and capacity for women choosing birth centre care.

Maternity A Ward

Number of Staffing Factors

01/03/2026 to 31/08/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	4	7%
SF2	Unexpected support staff absence/sickness	12	22%
SF3	Unable to fill vacant MW shifts	0	0%
SF4	Unable to fill vacant support staff shifts	0	0%
SF5	Staff on transfer duties	0	0%
SF6	MW redeployed to other area	8	15%
SF7	Support staff redeployed to other area	2	4%
SF8	Support staff less than rostered numbers	0	0%
SF9	No support staff available	15	28%
SF10	MW supporting triage	0	0%
SF11	No admin staff available	13	24%
TOTAL		54	

*The % is rounded to nearest whole number

Refer to slide 7 for analysis if the data

Staffing Factors

01/03/2026 to 31/08/2026



Maternity B Ward

Refer to slide 7 for analysis if the data

Number of Staffing Factors

01/03/2026 to 31/08/2026

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	6	25%
SF2	Unexpected support staff absence/sickness	0	0%
SF3	Unable to fill vacant MW shifts	1	4%
SF4	Unable to fill vacant support staff shifts	1	4%
SF5	Staff on transfer duties	0	0%
SF6	MW redeployed to other area	13	54%
SF7	Support staff redeployed to other area	3	13%
SF8	Support staff less than rostered numbers	0	0%
SF9	No support staff available	0	0%
SF10	No admin staff available	0	0%
SF11	Reduced NNU support for NIPE	0	0%
TOTAL		24	

*The % is rounded to nearest whole number

Staffing Factors

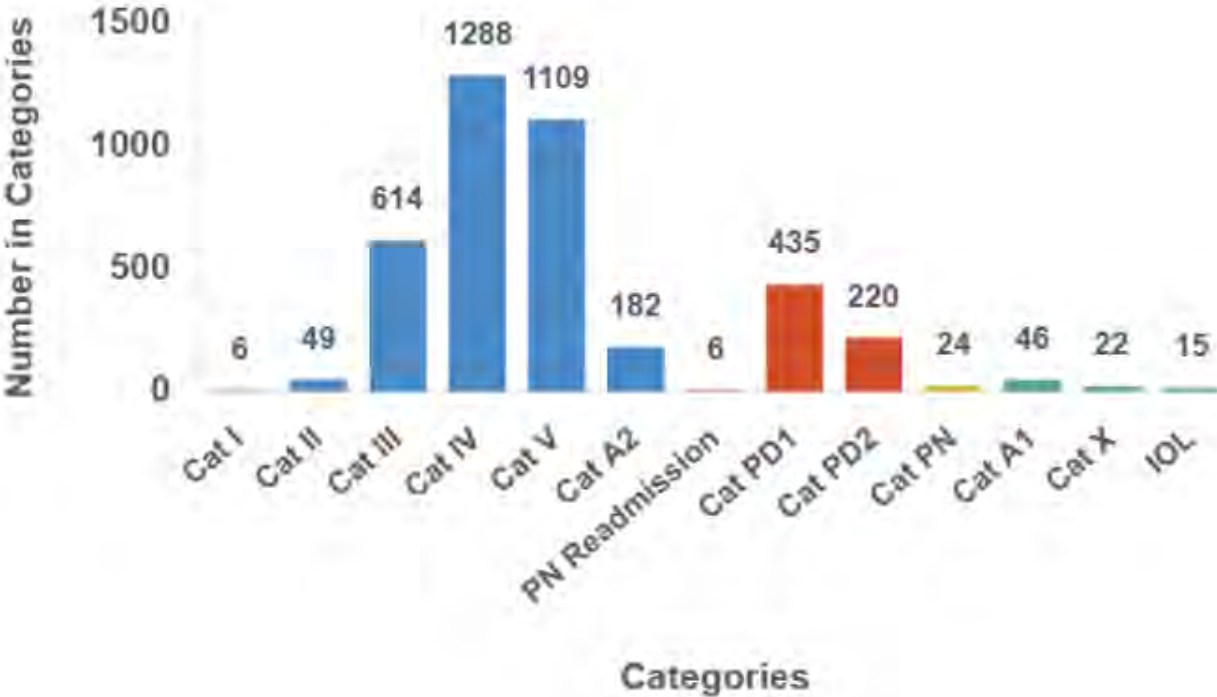
01/03/2026 to 31/08/2026



Refer to slide 7 for analysis if the data

Intrapartum & Non-Birthing Categories

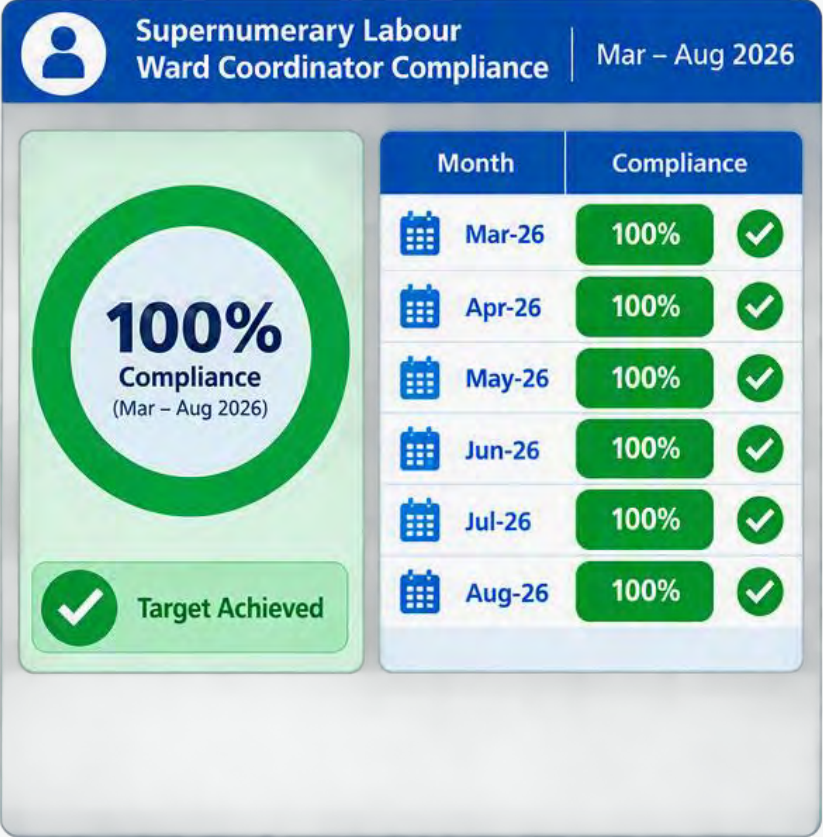
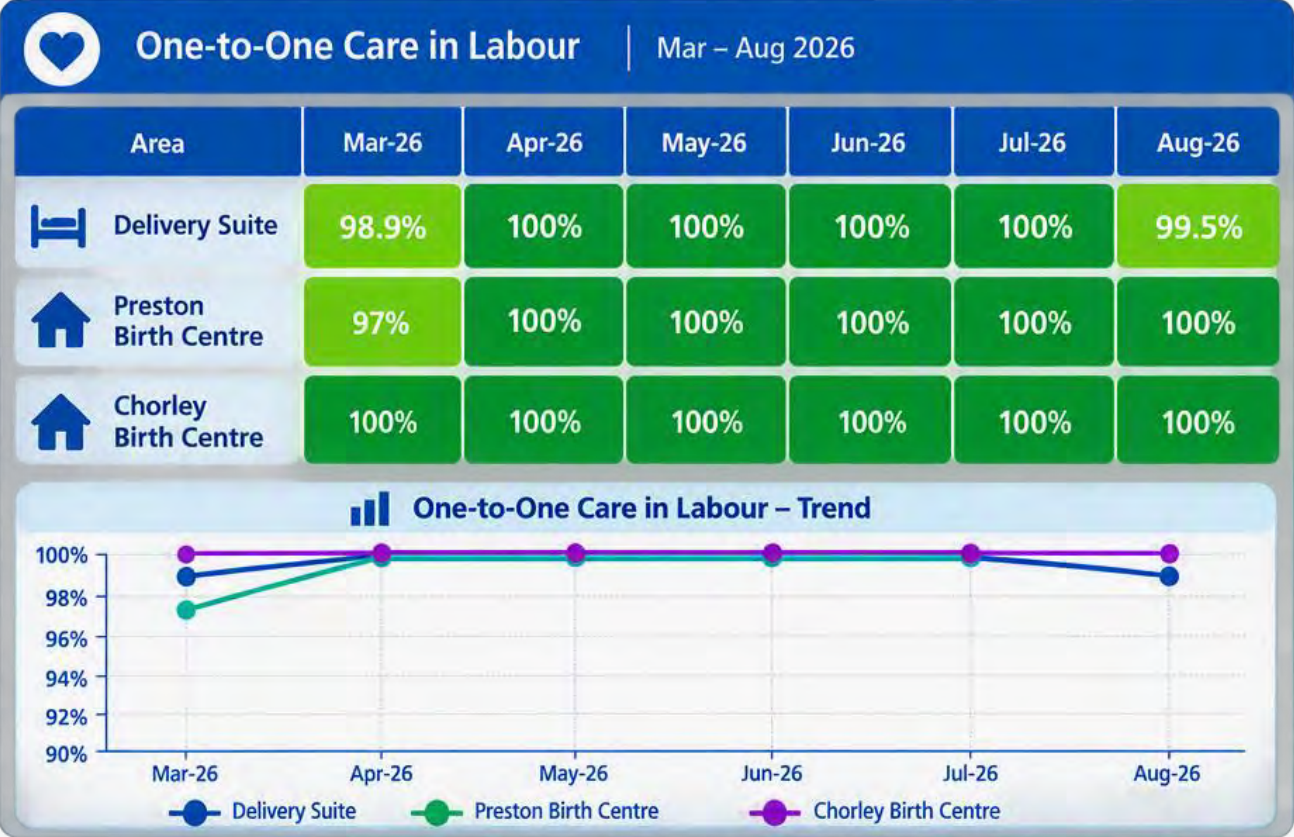
01/03/2026 to 31/08/2026



Categories	Number in Categories	Percentage
Cat I	6	0%
Cat II	49	1%
Cat III	614	15%
Cat IV	1288	32%
Cat V	1109	28%
Cat A2	182	5%
PN Readmission	6	0%
Cat PD1	435	11%
Cat PD2	220	5%
Cat PN	24	1%
Cat A1	46	1%
Cat X	22	1%
IOL	15	0%
TOTAL	4016	

*The % is rounded to nearest whole number

Analysis: 4,016 episodes of care were recorded over the six months, concentrated in the higher acuity groups - Category IV (32%) and Category V (28%) together account for 60%, with Category III a further 15%. Non-birthing activity adds a significant load, mainly postnatal day care (PD1 11%, PD2 5%). Most care is therefore complex or high dependency, which supports the staffing pressures shown on the preceding slides.



One-to-One Care in Labour compliance on Delivery Suite was 99.5% in August 2026 against the expected standard of 100%. This represents a single episode where continuous one-to-one care was not achieved. Preston and Chorley Birth Centres maintained 100% compliance, and Supernumerary Labour Ward Coordinator compliance remained at 100%, providing ongoing assurance that safe staffing standards were consistently maintained across maternity services.

Obstetric Workforce Update

The Obstetrics and Gynaecology team has 22 consultants. Nine work only on the obstetric on-call roster, three cover both areas, and eleven work on the gynaecology roster. One new full-time consultant started in September 2026, and another will start in February 2027.

To make sure there is an ability to respond more quickly outside normal working hours, a tier 2 rota has been created to increase resident doctor medical cover to the evening, night and weekend shifts, so two senior trainees are now on duty. This change started on 5 August 2026. This change occurred after listening to staff and patients and looking at safety information, and it fits with the arrival of new doctors joining the rotation alongside the existing clinical fellows and specialist doctors.

Sickness absence, unfilled posts and maternity leave have reduced the number of consultants available and the time they have for leadership work. The divisional leadership team is working with executive colleagues to stabilize the service. This includes recruiting two more full-time obstetric consultants and one full-time gynaecologist, so the two Consultant on-call rosters can be run separately and the team becomes more resilient. This also responds to what safety and feedback information is telling us.

The service has also experienced heightened demand for caesarean sections, running at a 12-month average of 44% of all births (peak elective caesarean section rate = 19.3%, peak emergency caesarean section rate = 35.5%). Due to the complexity of the cases, all caesarean sections lists should be scheduled to be performed by a consultant, SAS or specialty doctor of suitable seniority. The current scheduled capacity for caesarean sections is 4.5 theatre sessions per week, equating to around 11-12 patients. The service is routinely running additional capacity lists to provide a further 5-6 caesareans at weekends, and benign gynaecology operating is also being cancelled in order to provide further maternity theatre capacity. The caesarean section capacity and demand review is currently underway to assess existing service provision, activity levels, and future requirements. The findings and recommendations from the review will be presented to the committee in due course.

The risk is still elevated due to the reliance on temporary staff and limited specialist cover. Obstetric staffing is checked every week and the use of agency staff is mitigating any rota gaps. The staffing risks and actions being taken are set out in the table on slide 15. The table below shows our 24-hour obstetric medical staffing levels and how well we meet the Royal College of Obstetricians and Gynaecologists (RCOG) standards.

	Mar	Apr	May	Jun	Jul	Aug
Actual	100%	100%	100%	100%	100%	100%
Compliance with “Roles and Responsibilities of the Consultant providing acute care” (standard: ≥80%)	93%	100%	91%	100%	100%	100%

Anaesthetic workforce

Compliance for immediately available duty anaesthetist for the obstetric unit 24 hours a day

	Apr	May	Jun	Jul	Aug	Sept
% compliance	100%	100%	100%	100%	100%	100%

Monitoring compliance with the requirement for an immediately available duty obstetric anaesthetist 24 hours a day provides assurance against the Maternity Incentive Scheme (MIS) Year 8 workforce and safe staffing standards. Given the specialist nature of perinatal care and the critical role of anaesthetic services in supporting labour, emergency obstetric interventions and maternal deterioration, obstetric anaesthetic rota cover is prioritised to ensure timely access to expert care. Compliance remained at 100% throughout the reporting period, demonstrating sustained provision of dedicated obstetric anaesthetic support and alignment with national safety expectations.

Neonatal Medical Workforce



Workforce Tier	Funded Establishment (WTE)	In Post	Vacancy Gap (WTE)
Tier 1	7.0 WTE	5.4 WTE	1.6 WTE
Tier 2	6.80 WTE	5.6 WTE	1.20 WTE
Tier 3	10.1 WTE	9.63 WTE (1 honorary until Feb 2027, 1 Locum 0.6 WTE until Dec 2026)	0.47 WTE
Band 8a/8b ANNP's	7.0 WTE 8a (3WTE) 8b (4WTE)	5.6 WTE 8a (2.6 WTE) 8b (3 WTE)	1.4 WTE 8a (0.4 WTE) 8b (1 WTE)

Neonatal medical staffing continues to be reviewed against BAPM workforce standards to ensure the service remains safe, sustainable and appropriately resourced to meet current and anticipated demands. The Neonatal Intensive Care Unit has a current establishment of 30.9WTE plus 1.0WTE honorary contract until February 2027. The service establishment is compliant with BAPM standards apart from consultant cover, with a gap of 4 hours within the week without resident consultant cover. A plan is in place to review jobs plans and then review how any excess PA time could be utilised to recruit another consultant on top of the existing Locum consultant post (2 consultants in total). Consideration of a business case to support recruitment will then take place if required. At consultant level, interim arrangements are supporting delivery of the 1:8 on-call rota. A review of consultant job plans is planned to ensure alignment with service demand and future workforce requirements, with opportunities being explored to develop an additional substantive consultant post through workforce redesign.

The service is compliant with the Tier 1 and Tier 2 rota. However workforce unavailability and unfilled vacancies are affecting the services ability to cover all of the funded requirement. Work is ongoing with the Divisional Medical Director and Clinical Director for neonates to review any additional workforce requirements and a an action plan is being collated.

Neonatal Nursing workforce

A review of neonatal workforce capacity has identified several significant gaps in specialist nursing and allied health professional staffing when benchmarked against British Association of Perinatal Medicine (BAPM) standards and recommendations highlighted within the Neonatal GIRFT report. While the neonatal service continues to deliver safe care, workforce shortfalls present risks to quality improvement, developmental care, family integrated care, infant feeding support, and the wider multidisciplinary service.

Positive progress has been achieved through recent investment in digital nursing, education, and governance capacity. However, further workforce development will be required to achieve full compliance with recommended standards and support the delivery of equitable, high-quality neonatal care

The National Neonatal workforce calculator (ACD report) has identified a deficit of 2.0WTE in available cot side nurses.

The Neonatal GIRFT review identified that workforce gaps remain the key challenge in achieving compliance with recommended neonatal standards. These gaps span specialist nursing roles and multidisciplinary team members who are essential to delivering modern neonatal care.

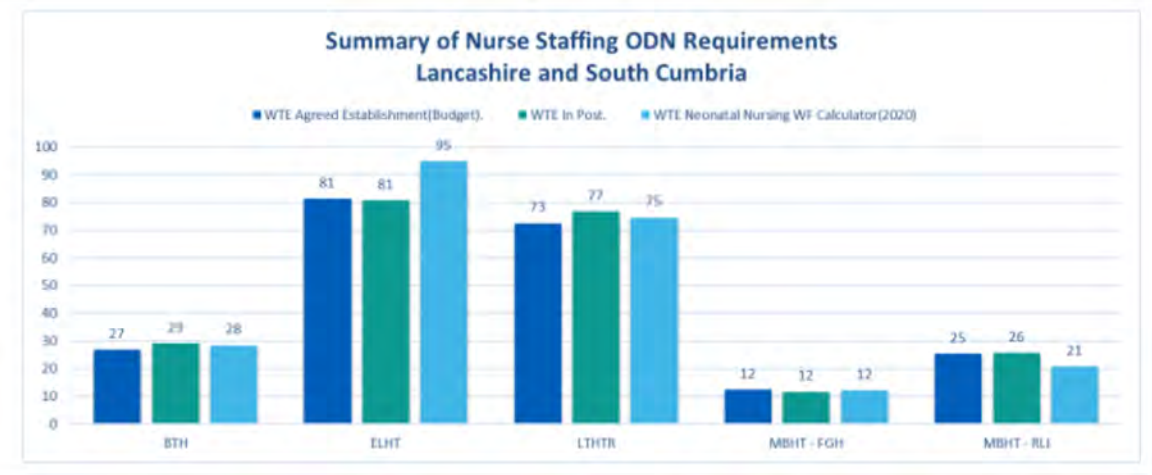
National expectations emphasise the importance of multidisciplinary support services, including therapy services, psychology, pharmacy, infant feeding, developmental care, family integrated care (FiCare), discharge planning, and bereavement support.

Transitional care is a key baseline requirement to keep mothers and babies together and prevent avoidable admissions to the neonatal unit. It requires that neonatal and maternity teams work together to provide care for a defined cohort of babies who meet the transitional care threshold and that there is a defined staffing model in place. Transitional care has operated within the maternity ward for many years and neonatal nursing staff have supported this with 1 neonatal nurse being allocated per shift from the neonatal establishment. With the increase in complexity and need to staff all 28 cots on the neonatal unit it has become apparent that this is not a sustainable model going forward. Frequently the neonatal unit is not able to provide the neonatal nursing cover for transitional care and it is recommended that there should be an uplift of 5.51WTE neonatal nursing staff to adequately staff the transitional care service 24 hours 7 days a week. This would ensure that the quality and safety of care for these very vulnerable babies and families is maintained and that separation of mother and baby is avoided.

The Divisional Nursing Director for Young People, Children and Babies is working collaboratively with the Chief Nursing Officer to develop and implement a clear action plan for neonatal nursing staffing, ensuring that workforce provision is fully aligned with the standards and requirements set out by the British Association of Perinatal Medicine (BAPM).

Neonatal Nursing workforce

The Trust has received data from the Activity, Capacity and Demand report (ACD) from the Northwest Neonatal Network for 25/26. The WTE funded establishment, staff in post and demand required is demonstrated in the Summary of Nurse Staffing ODN Requirements graph alongside. This indicates the NICU requires an additional 2.0WTE nurses to be compliant with the national Workforce calculator.



Cot side neonatal Nursing Capacity

The requirements for nurse staffing are based on the number of cots required based on actual intensive care, high dependency care and specials care numbers. Staff providing transitional care or specialist roles are not included in the calculation.

The table alongside indicates that in previous years the number of recommended cots has been slightly smaller than the commissioned cot base. In the last year this has increased and now the demand is meeting the number of cots available (28).

3.7.3 Lancashire & South Cumbria Cot Activity

Lancashire & South Cumbria	Cots D: Demand A: Actual															
	D IC	D IC	D IC	A IC	D HD	D HD	D HD	A HD	D SC	D SC	D SC	A SC	Total D	Total D	Total D	Total A
	23/24	24/25	25/26	25/26	23/24	24/25	25/26	25/26	23/24	24/25	25/26	25/26	23/24	24/25	25/26	25/26
BTH	0.6	0.8	0.7	2	2.2	2.1	2.0	2	8.3	7.8	7.3	12	11.1	10.8	9.9	16
ELHT	7.3	5.2	5.5	6	10.1	7.6	10.8	8	14.7	15.1	16.6	20	32.1	27.9	32.9	34
LTHTR	4.4	4.4	5.0	6	6.6	7.3	7.3	8	13.5	13.3	11.3	14	24.5	25	23.5	28
MBHT – FGH	0.1	0	0.0	0	0.1	0.1	0.1	0	2.2	2.2	2.2	4	2.4	2.3	2.3	4
MBHT – RLI	0.3	0.3	0.3	1	1.7	1.9	1.6	2	5.7	5.1	4.5	7	7.7	7.3	6.5	10
Total	13	11	12	15	21	19	22	20	44	44	42	57	78	74	75	92

Key: Short by 1 or more cot = Red, over by 1 or more cot = Yellow, Correct number within in 1 = Green

Table 3.7.3

Specialist Neonatal Nursing Capacity

Current funded establishment

0.7 WTE specialist nurse funding

- Retinopathy of Prematurity (ROP)
 - Infection Prevention and Control (IPC)
 - Safe Sleep
 - Bereavement Support
 - Neurodevelopmental Care
 - Discharge Planning
 - Family Integrated Care (FiCare)

1.0 WTE funding

- Infant Feeding
- Research

Whilst these posts provide important leadership and oversight functions, the breadth of responsibilities assigned to a limited number of staff presents a risk to sustainability and the ability to fully deliver all workstreams

Allied Health Professional and Specialist Support Workforce Capacity

Current staffing levels remain below recommended establishment levels in several key professional groups:

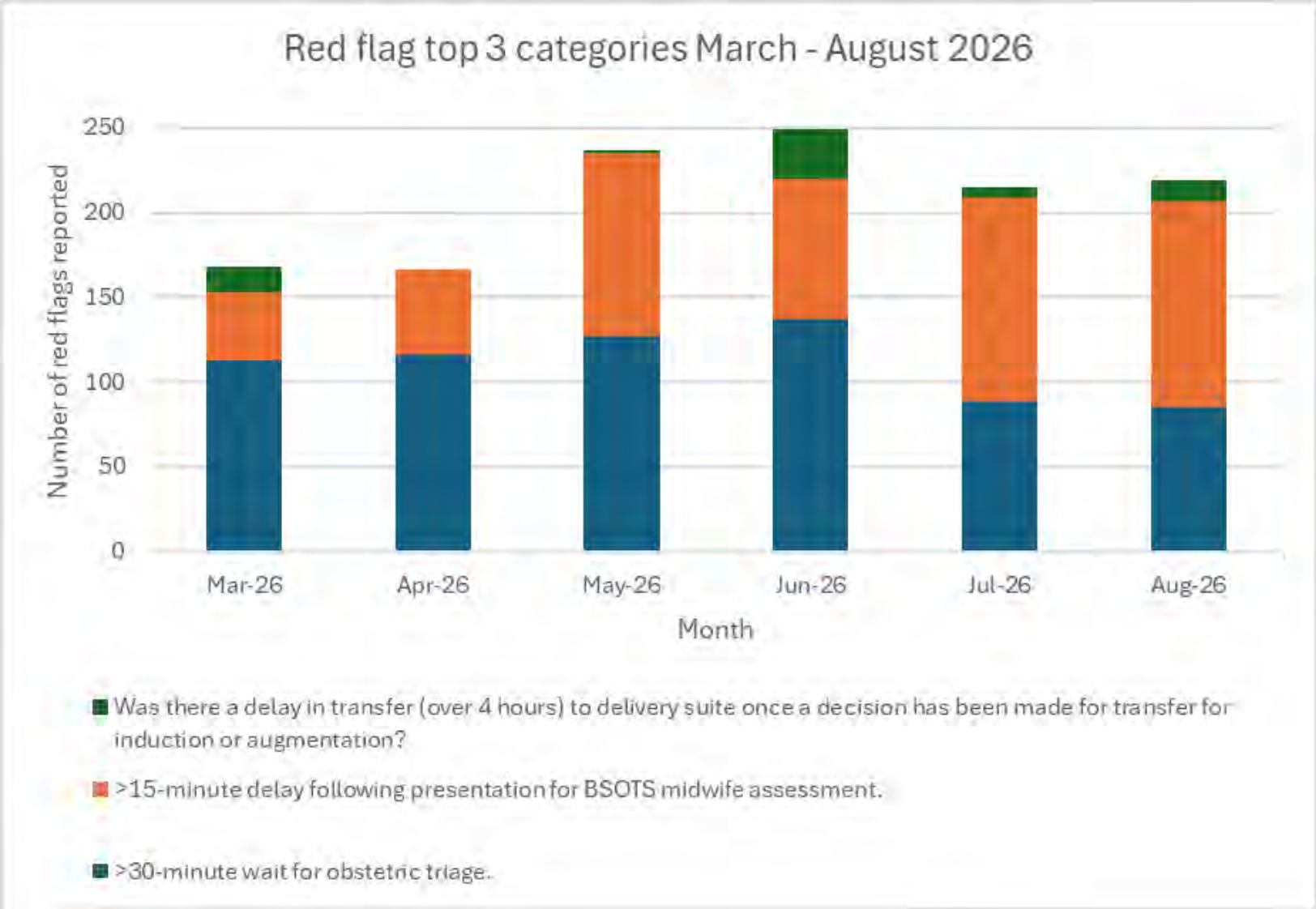
Professional Group	Current WTE	Recommended WTE
Dietitian	0.7	1.6
Physiotherapist	0.6	1.5
Occupational Therapist	0.7	1.5
Speech and Language Therapist	0.6	1.3
Psychologist	0.0	1.7
Pharmacist	0.4	1.75

The most significant gap exists within psychology services, where there is currently no dedicated neonatal psychology provision despite a recommended establishment of 1.7WTE. A business case has been approved in division and is progressing through corporate process.

Neonatal Nursing Workforce Positive Developments

Digital Transformation	Substantive funding secured and recruitment completed for 1.0WTE Digital Nurse This role will support digital maturity, data quality, and service improvement initiatives.
Education and Governance	Substantive funding continued for 2.0WTE Educators with Governance Responsibilities These appointments strengthen workforce development, clinical education, quality assurance, and governance oversight.
Workforce Development	12 months extended fixed-term funding secured for Cot-Side Educator. This role enhances bedside support, staff development, competency attainment, and patient safety. It has been funded by the ODN in recognition of the number of students that the unit supports on the Foundation in Neonatal Care (FIN) and Qualified in Speciality (QIS) courses.
Pharmacy Support	The pharmacy department has secured additional funding and is currently recruiting to a new post for a specialist pharmacist.

Maternity & Neonatal Red Flag Incidents



Between March and August 2026, a total of 1389 Ulysses reports were submitted to report maternity red-flag indicators, equating to a monthly average of 231 red-flag entries.

The three most frequently reported categories across the six month period were:

- Delay in medical review (BSOTS)
- Delay in midwifery review (BSOTS)
- Delay in transfer during induction of labour

The highest number of incident reports with maternity red-flag indicators was a >30 minute wait for obstetric triage, with 666 reported between March and August 2026.

Analysis of themes and trends demonstrates that these three categories consistently represented the highest-volume red-flag triggers each month. Data over the six month period, also shows a recurrent pattern of >2-hour delays in the induction of labour process, emerging as the fourth most reported maternity red-flag indicator throughout the reporting period.

Skill mix: Right Place, Right Time

The service continues to maintain robust systems and processes to ensure that staff are deployed effectively and sustainably so that women and babies receive the right care, first time, in the right setting. This includes effective workforce planning, staff deployment, roster management, and clear escalation processes when concerns arise.

A range of oversight mechanisms are in place to provide assurance that staffing levels remain appropriate to meet demand safely. These mechanisms act as a continual assessment of capacity, acuity, workforce availability, and clinical activity. Workforce deployment is regularly reviewed to maximise frontline clinical capacity, and specialist roles are supported through cross-training and skill-sharing initiatives to ensure continuity of care and reduce reliance on individual post holders.

Maternity Bleep Holder (Unit Coordinator) 24hour cover	The Matron of the Day: (MOD) Mon to Fri 9 –5	Daily shift-level assessments and safety huddles.	Maternity Daily Situation Report (SitRep) and Regional ICB GOLD Call.	Intrapartum Acuity Tool: Birthrate Plus	Community Safety Huddle
Maintains oversight of capacity, workload and workforce across the maternity service. Assesses staffing to ensure the right skill mix and the right staffing levels/ acuity in each clinical area.	Point of escalation and support for Unit Coordinator. Providing oversight and leadership making decisions managing-deployment of staff as required.	Held at 9:30am and attended by each clinical area to review staffing and activity. Capacity and flow are considered, and clinical care requirements are reviewed.	The service submits data daily to NHS England in relation to delays in induction, deferred caesarean section and maternity and neonatal unit diverts.	Birth Rate Plus acuity tool is utilised to assesses the needs of women during labour, birth and in the early postnatal period.	Undertaken daily by the team leader of the day to review and oversee the community midwifery activity, identify issues and ensure effective communication to workers who are remote from the main site.
Provides early recognition of potential capacity issues, escalating concerns to MOD early on so active measures can be put in place.	Utilises the Northwest Maternity Escalation Policy & Operational Pressures Escalation Levels Maternity Framework (OPELMF) to guide safe and appropriate responses to manage significant surges in demand	Board Rounds are undertaken at 8:30am 1:30pm 5pm and 20:30 pm. Additional safety huddles are held as part of the obstetric handover at 17:00 and 20:30	(Monday to Friday 10am) including the regional ICB GOLD call to identify and address shortfalls proactively and safely across the Lancashire and South Cumbria region.	This classification system records acuity and complexity every 4 hours, 24/7. The tool enables the service to determine if staffing is adequate in real time.	Team Leader of the day maintains oversight and provides leadership making decisions and managing-deployment of staff in community as required.

Maternity Training Compliance



Overall Compliance
(August 2026)
93%



Fetal Monitoring & Surveillance
(August 2026)
99%



PROMPT Training
(August 2026)
93%



Target
>90%

 Compliance by Training Area and Staff Group (%)

Month	Training Area	Midwives	Obstetric Consultants	Trainee Doctors	MSW	Anaesthetic Consultants	Anaesthetic Rotational	Overall Compliance
 Mar 2026	Fetal Monitoring & Surveillance	96%	100%	95%	–	–	–	96%
	PROMPT Training	98%	100%	86%	93%	100%	95%	96%
 April 2026	Fetal Monitoring & Surveillance	99%	100%	100%	–	–	–	99%
	PROMPT Training	98%	91%	78%	100%	100%	98%	96%
 May 2026	Fetal Monitoring & Surveillance	99%	100%	100%	–	–	–	99%
	PROMPT Training	98%	90%	96%	98%	100%	100%	98%
 June 2026	Fetal Monitoring & Surveillance	100%	100%	100%	–	–	–	100%
	PROMPT Training	99%	90%	100%	100%	100%	100%	99%
 July 2026	Fetal Monitoring & Surveillance	99%	100%	100%	–	–	–	99%
	PROMPT Training	98%	100%	91%	100%	93%	100%	93%
 August 2026	Fetal Monitoring & Surveillance	100%	90%	100%	–	–	–	99%
	PROMPT Training	99%	100%	64%	100%	100%	63%	93%

 Executive Summary



Overall Position
Training compliance has remained stable over the last six months with overall compliance consistently above 90%.



August Highlight
In August, reduced compliance within PROMPT training was observed amongst Trainee Doctors (**64%**) and Rotational Anaesthetic staff (**63%**) following workforce rotation.



Next Steps
All new doctors are booked onto training and compliance is expected to return to target by November 2026.



Assurance
Continued monitoring in place through established governance processes to ensure ongoing compliance with MIS Year 8 requirements.

Key:

≥90% (On target)

86–89% (Monitor)

<86% (Below target)

– Not applicable / no data

 Data shown as % compliance

 | Source: Maternity Training Records

NHS England Jun 2026

Overall page 100 of 357

Neonatal Training Compliance



Risk Register

The risk register for perinatal services currently includes five high level risks (risk rating =>15) and seven significant risks (risk rating 8-12) related to safe staffing, all of which align with known operational pressure points. These risks are actively reviewed by designated owners and handlers and are overseen through the maternity safety and quality committee, with additional scrutiny from the Risk Management Group. Each risk includes an assessment of current ratings, existing controls, and gaps requiring further action. The table below outlines these risks.

Risk ID	Title	Current Risk Rating
1358	Reduced administrative support (medical secretaries) in the Obstetric and Gynaecology service	16
1592	Delays in induction of labour process impacting upon capacity and flow, safety, and quality of experience	15
2089	Maternal Medicine centre lacking funding for consultant Obstetric Physician and Specialist input from Medical Specialities	20
581	Maternity staffing deficit impacting upon the quality and safety of service provided, experience and levels of satisfaction	15
1673	There is a risk, due to no access to a psychology service, of a negative impact upon the health and wellbeing of neonatal families	15
2088	Middle grade rota staffing does not meet the capacity and demand of the maternity and gynaecology services	12
62	Insufficient medical cover for neonatal services	12
885	The neonatal outreach service has limited staff establishment, resulting in a reduced service provision for babies and families	9
126	Unable to provide sufficient nursing establishment at BAPM standard to manage peak neonatal activity/acuity	12
1858	Inability to facilitate four birth place options	12
1688	Maternity Assessment Suite (MAS) - Partial implementation of the Birmingham Symptom Specific Obstetric Triage (BSOTS) system	12
1708	Deferring and rearranging planned consultations in midwifery led services (community midwifery)	9

NHS England published the National Maternity Triage Specification on 1 July 2026 following the Baroness Amos Independent Investigation. Trusts are required to undertake a Board-level review of maternity triage services within a three-month timeframe, complete a gap analysis against the national specification, develop an implementation plan and report progress to NHS England.

Full compliance with the specification is expected within 12 months of publication. The review focuses on safe staffing, timely assessment, governance, performance monitoring and consistent access to high-quality maternity triage services. Table 23 provides a high-level prospective action plan with expected timelines for completion.

The service has completed the national maternity triage benchmarking exercise and will submit the required evidence to NHS England by 25 September 2026. A detailed paper outlining the current position, benchmarking outcomes, identified gaps, implementation requirements and high-level financial implications has been prepared and is progressing through the Trust's governance and Board approval processes. Subject to approval, the final evidence and supporting documentation will be uploaded to the NHS Futures platform within the required national timescale.

Maternity Assessment (Triage)

Q1 2026/27 Table 24	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Total women seen	958	1012	1016	1080	1111	1111
Seen within 15mins by midwife	95.00%	95.10%	87.40%	89.50%	85.10%	84.90%
Seen 16 - 30mins by midwife	3.30%	3.70%	6.90%	6.40%	7.70%	9.20%
Seen 31 - 60mins by midwife	1.70%	1.10%	4.20%	3.60%	6.40%	4.40%
Seen 61 - 120mins by midwife	0.00%	0.20%	1.30%	0.50%	0.70%	1.50%
Over 120mins before seen	0.00%	0.00%	0.20%	0.00%	0.10%	0.00%

Telephone Calls Received table 25						
	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Antenatal calls	952	1018	1082	991	1055	1168
Postnatal calls	94	63	107	81	91	83
Unspecified	1267	1317	1396	1454	1457	1671
Dropped calls	53	46	62	100	85	81
Total calls	2366	2452	2647	2626	2688	3003

An established monthly maternity triage audit is in place, which is in the process of being updated and aligned to the National Maternity Triage Specification (July 2026). The current audit provides assurance against standards including timely clinical assessment by a midwife, telephone triage, attendance data, responsiveness, escalation, medical review times, and service user experience.

To support the requirements of the National Maternity Triage Framework and facilitate detailed performance monitoring, a maternity-specific triage dashboard is planned for development. The dashboard will provide oversight of key triage metrics, including activity, timeliness of assessment and review, acuity categorisation, delays in care, staffing indicators, telephone triage performance, equity measures and service user experience. This will enable routine monitoring of compliance against national standards, support early identification of risks and trends, and provide assurance through maternity governance processes that women receive timely, safe and effective triage care.

Safety Standard E	Governance, Culture and Leadership
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MAS Triage Attendance Data Q1 2026/27 Table 26						
	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Total	958	1012	1016	1080	1111	1111
Reduced FM	367	345	376	403	379	390
Raised BP	100	121	107	112	103	83
PV Bleed	63	87	59	53	57	74
Unwell/Other	117	133	112	142	174	143
? SROM	66	73	68	61	92	106
? Labour	63	49	73	84	79	78
Abdo pain	71	86	102	111	101	115
Postnatal	60	43	68	59	71	65
Scan review	34	55	44	33	24	33
Unspecified	0	0	0	0	0	0
CTG monitoring	17	20	7	22	31	24

Culture & Leadership Improvement

Creating the conditions for compassionate, safe care



Lancashire Teaching Hospitals
NHS Foundation Trust

Maternity & Neonatal
Culture Improvement



1. Perinatal Leadership Programme

- Leadership development for Matrons, Band 7 Leaders and Consultants
- Shared vision and leadership expectations
- Role clarity, accountability and RACI framework
- Compassionate and inclusive leadership behaviours



2. Listening & Staff Voice

- SCORE Survey
- OD Listening Events
- Culture Conversations
- Freedom to Speak Up engagement and champions
- Staff voice shaping improvement actions



3. MDT Team Effectiveness

- Medical, midwifery and nursing team development
- Shared decision-making
- Escalation and collaboration
- Professional respect and accountability
- Cross-professional working and team cohesion



4. Culture Contract "How We Behave Matters"

- Non-negotiable behaviours
- Civility, kindness and professionalism
- Human Factors approach
- Zero tolerance to bullying, harassment and discrimination



5. Inclusion & Psychological Safety

- Anti-racist and inclusive culture programme
- EDI awareness and development
- Belonging and wellbeing
- Psychological safety and speaking-up culture



6. Continuous Improvement

- Culture Action Plan delivery
- Leadership accountability
- Staff feedback loops
- Culture measurement and assurance
- Continuous learning and improvement

Progress to Date



13 Culture Conversation sessions completed



Perinatal Leadership Programme established



SCORE Survey and OD Listening Events informing priorities



MDT culture development underway



Culture Contract co-produced with teams



Inclusion, FTSU and Psychological Safety initiatives progressing



We are building a positive, inclusive and respectful culture where everyone feels valued, heard and empowered to deliver the best possible care for women, babies and families.

The Divisional culture review into Maternity and Gynaecology services was commissioned in April of 2025, following triangulation of themes and trends indicating that a more systemic review of the culture was needed to understand the driving factors contributing to the cultural challenges and to enable the right, targeted action to be taken.

From engaging with colleagues high level themes were identified which helped to shape the actions required. These findings were shared with the Trust Board and with ongoing support from the Organisational Development Team an comprehensive action plan was developed and work has commenced on these actions.

The Cultural Action plan is included in Ancillary Report 2

Equality and Diversity



The Programme



The **NHS Race Health Observatory**, will be delivering steps 2, 3 & 4 of the programme. They are working alongside the **White Ribbon Alliance UK**, **Inspiring Hope** and **Aqua**. This is a creative and innovative consortium with vast experience in transformative work to address racism and discrimination.

Maternity and Neonatal Services will be participating in the National Perinatal Equity and Anti-Discrimination Programme. This looks at improving outcomes for service users and staff as well as influencing and supporting culture change.

The leadership team have already engaged with the regional webinar and the individual Trust specific meeting. Individuals have been identified to participate in the programme to enable the most effective reach and outputs from across the services.

The programme will officially launch in January 2027 and is expected to run for around 9 months.

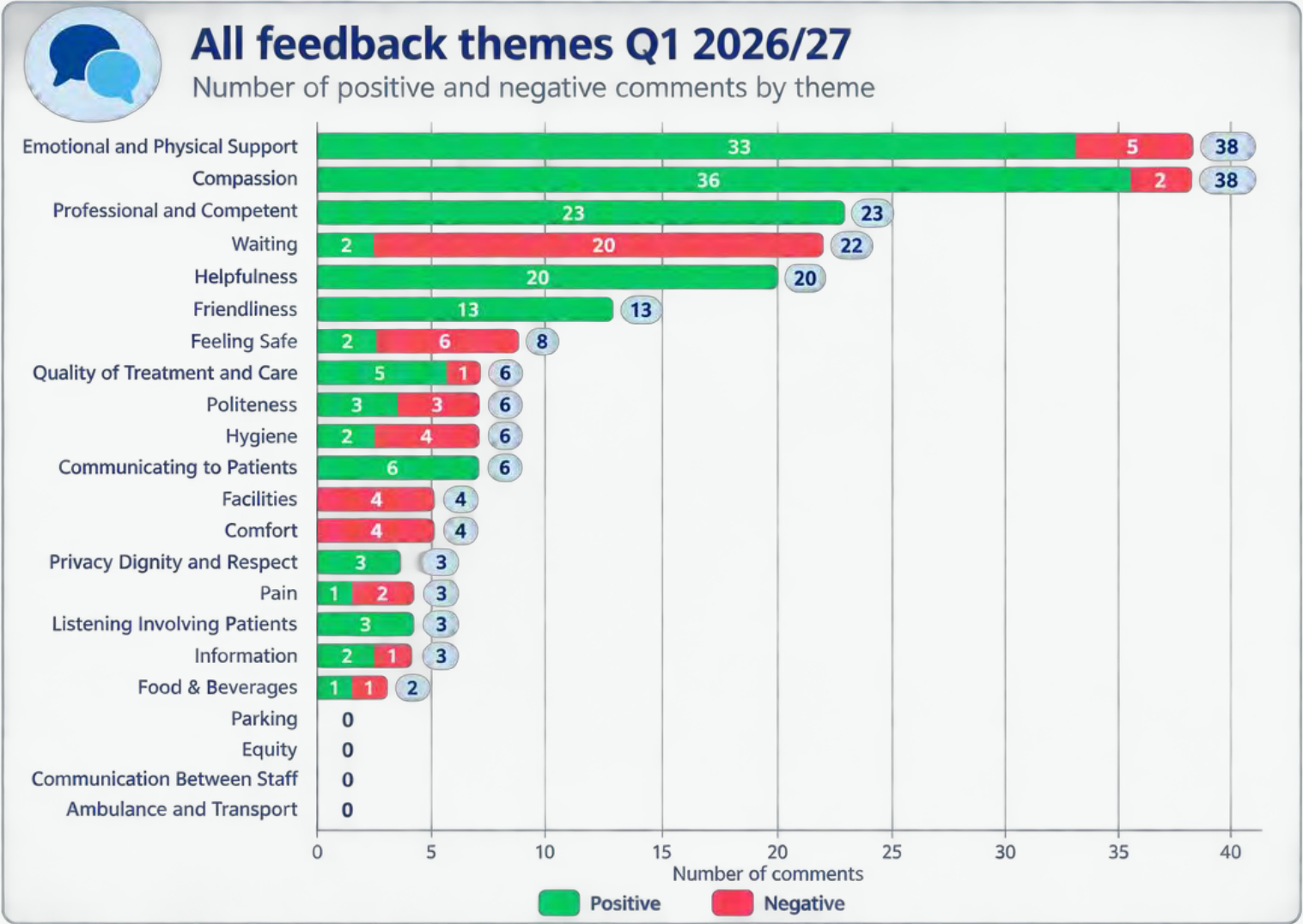
The Chief Nursing Officer has agreed to be the Executive Sponsor and this will ensure that the Board and Executive Team are sighted on the programme of work.



Train	Retain	Reform
Clinical placement capacity has been reviewed collaboratively with Higher Education Institutions (HEIs) to enhance placement quality, student support and learning opportunities across maternity services.	Enhanced support and retention of newly qualified and student midwives has been developed providing three-months supernumerary status for Newly Qualified Midwives (NQM), regular retention meetings, peer support forums, one-to-one development support, surveys and ongoing student midwife catch-up sessions.	Workforce deployment has been reviewed using Birthrate Plus, patient experience and Red Flag data to inform staffing model redesign and service reconfiguration.
A sustainable Practice Assessor workforce has been maintained, with 140 trained assessors and ongoing assessor development embedded into the preceptorship programme.	The NQM preceptorship programme has been reviewed and updated to align with national, regional and local priorities, ensuring new midwives are supported to develop the skills and competence required to meet service needs.	A Birthrate Plus assessment has been undertaken and an associated workforce action plan completed to ensure workforce establishment, skill mix and staffing deployment are aligned to service demand and acuity.
There are regular support and engagement sessions for student midwives, using learner feedback to identify areas for improvement and enhance the overall placement and learning experience.	A Band 7 leadership development programme aligned to NHS England guidance has been developed and implemented, strengthening leadership capability, workforce development and succession planning.	Workforce sustainability has been strengthened through ongoing monitoring of vacancies and recruitment trajectories, including the successful appointment of 13.4WTE Band 5/6 midwives through the national over-offer scheme.

The Maternity Workforce Action Plan is included in Ancillary Report 3.
24 out of the 25 actions are complete with one action ongoing associated with the culture review and a further iteration will be developed.

Patient Experience





Key points



Emotional and Physical Support and Compassion received the highest volume of feedback (**38 comments each**).



Most feedback was positive, particularly for Emotional and Physical Support, Compassion, Professional and Competent and Helpfulness.



Waiting was the largest source of negative feedback (**20 negative comments**).



Several themes had **very low or no comments**, including Parking, Equity, Communication Between Staff and Ambulance and Transport.

The service is in the first phase of the implementation of near to real time feedback and aims to use this as a means of addressing feedback themes.

Theatre 4 development and Midwifery and obstetric staffing recruitment are focused on addressing the delays within the feedback.



Total comments
182



Positive
130
(71%)



Negative
52
(29%)



Most positive theme
Compassion
(36 positive)



Largest negative theme
Waiting
(20 negative)

Conclusions and Recommendations

The Perinatal Safe Staffing Review provides overall assurance that maternity and perinatal services continue to deliver safe care despite ongoing workforce and operational pressures. Investment in midwifery, obstetric and neonatal services has strengthened workforce resilience, with high compliance across key safety indicators including obstetric and anaesthetic cover, one-to-one care in labour, mandatory training and established escalation processes. The service continues to demonstrate robust governance, effective workforce oversight and a commitment to learning and improvement.

Workforce gaps persist within neonatal nursing and allied services including: psychology, therapy services, pharmacy and specialist neonatal roles when benchmarked against national standards for BAPM.

Rising service acuity, increasing maternity triage activity, delays associated with induction of labour and ongoing medical workforce availability continue to represent a pressure point which will continue to be monitored. In line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Divisional Midwifery and Nursing Director and the Chief Nursing Officer confirms that they are satisfied with the outcome of the safe staffing review.

The Safety & Quality Committee is asked to:

1. Endorse the approval of the Perinatal Workforce report and associated action plans.
2. Scrutinise the outcomes for perinatal services, noting the Safety and Quality committee have reviewed in detail the contents of the report.
3. Note there are gaps in provision to meet AHP and psychology standards in Neonatal Unit and a review of the medical model is underway to seek to address the gap in the service.
4. Note the requirement to fund as planned year 2 of Birthrate plus and for this to be included as part of the budget setting process.
5. Accept, in line with NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer and Chief Medical Officer confirm that they are satisfied with the outcome of the annual safe staffing assessment and that, while risks remain that require active management, approved staffing levels approved (with the addition of the 2 additional obstetricians) are considered safe, effective and sustainable.

Maternity Safety, Quality and Effectiveness Report

Sep 2026 committee meeting with performance to Aug 2026



Patients



Performance



People



Productivity



Partnerships



Key to Metric Variation, Assurance Icons & Dashboard Headers

Key to Metric Variance and Assurance Icons

Assurance Icon	Variation Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
		Failing target and getting worse. (Exception Report Needed)	Close to target and getting worse. Check additional performance flag to say if mainly above or below target. Exception Report Needed	Passing target but getting worse. (Exception report needed)
		Failing target and no change happening. Process Review needed. May need exception report	Close to target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
		Failing the target but getting better. May need exception report	Close to target and getting better. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Key to Metric SPC Chart and Variance and Assurance Icons

Mean	Measure
Process Limit	Concerning special cause
Improving special cause	Target

Assurance Icons – How likely are we to hit the set target in future?		
It's possible the target could be either passed or failed within the expected month to month variation of the measure	The target will be consistently failed within expected variation unless the process is changed	The target will be consistently passed within expected variation unless the process is changed
Variation Icons – Is the measure showing signs of change over time?		
No signs of change over time evident in recent data	An example of concerning change is evident in the recent data	An example of positive change is evident in the recent data

Report Heading Explanation

Report Heading Explanation

Metric Description		Assurance	Variation	Target				
				Concern	Latest month target	Target rationale	Latest actual month	Latest month
	Example Measure				3.2	National	5	May-26

Assurance icon indicates whether the target is consistently passing, consistently failing or is inconsistently passing and failing

A flag icon is generated when a measure is capable of hitting target within expected variation but hasn't for the last 5 months or more

How the target is defined

Name of the metric

Variation icon indicates whether the most recent month is showing an unusual pattern of variation positive or negative

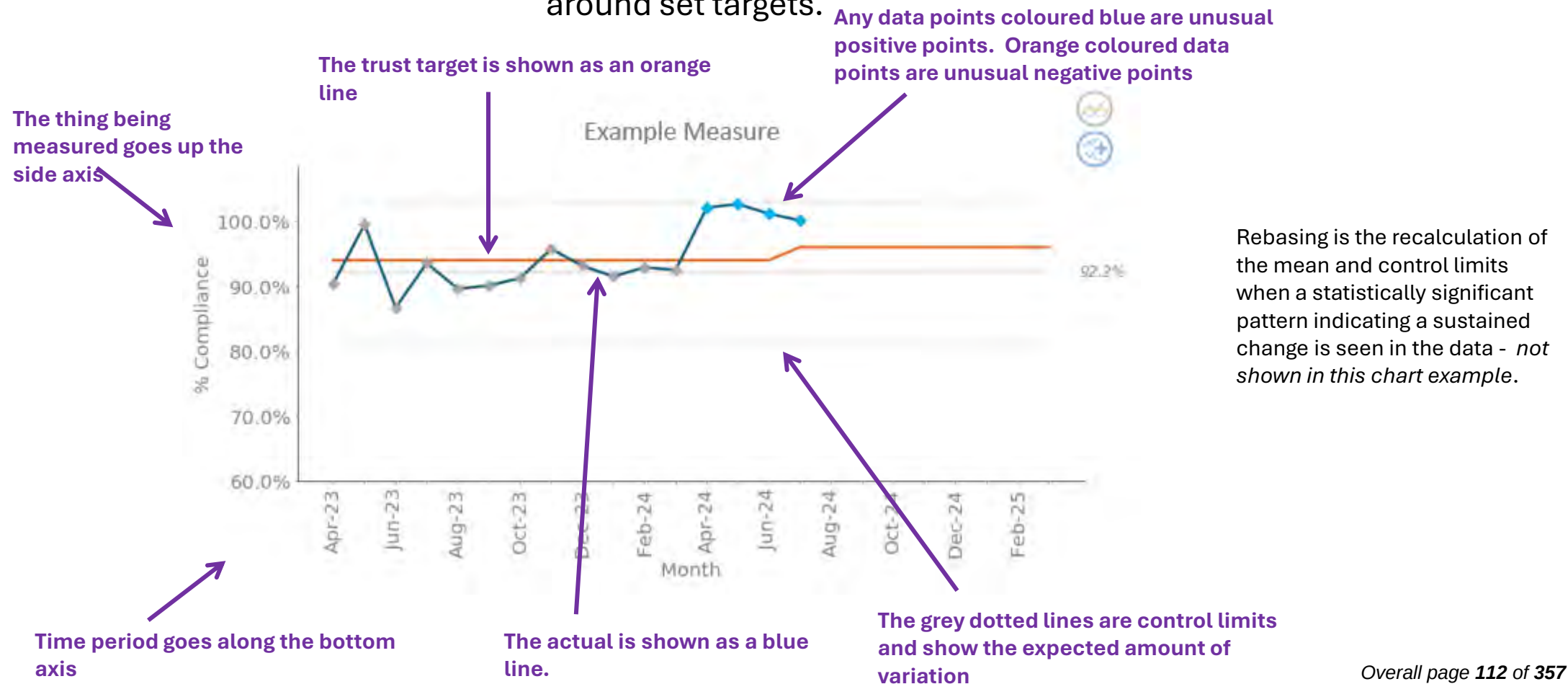
The target value

The most recent value

Most recent month

How to read Statistical Process Control charts (SPC)

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



Executive Summary SPC Metric Grid

Single Improvement Plan- Patients – SPC Metric Grid

	Measures			
 Recent concerning pattern or missing target	• APGAR score below 7 @5 minutes • Maternity BSOT standard (15 min) • Fill rate MSW Day • Staff sickness rate • Maternity divers • In- utero transfers declined to accept from other units (NICU) • NICU Closure • Delay in inductions • Elective sections stood down			
 Normal variation and on/around target	• Total stillbirths (rate per 1000 births) • Stillbirth excluding TOPFA (number) • Stillbirth excluding TOPFA (rate per 1000 births) • Neonatal death within 28 days (number) • Neonatal death within 28 days (rate per 1000 births) • PPH over 1500mL • Incidence of severe tears grade 3 and above • Breastfeeding initiation • Confirmed HIE grade 2 or above (37 weeks +) • Prevention of future deaths regulation 28 • CQC Enquiries • Maternal Death within 42 days • Maternity and Newborn Safety Investigations (accepted for review) • Incidents of moderate harm and above • Complaints • Compliments • Neonatal Nurse Staffing compliance to BAPM • Supernumerary status of DS coordinator at the start of every shift • One-to-one care in labour in Preston Birth Centre • One-to-one care in labour in Chorley Birth Centre • Fill rate RM Day • Fill rate MSW Night • Registered Midwife Agency hour fill rate percentage • Number of Consultant hours on obstetric unit • 24-hour acute obstetric medical staffing fill rate • Number of times home birth service stood down • Women who transfer to an alternative provider during induction of labour • In- utero transfers declined to accept from other units (maternity) • In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal) • Booked <10			
 Recent positive pattern or passing target	• HDU trained per shift • Maternity Triage NICE standard (30 min) • Fill rate RM Night • Registered Midwife shifts sent to agency • RCOG obstetric benchmarking compliance • Booked <13 • One to one care in delivery suite			
 Topic of high interest (always flagged for assurance report)	• APGAR score below 7 @5 minutes • PPH over 1500mL • Obstetric Anal Sphincter Injury (OASI)			

Executive Summary

The Perinatal Quality Surveillance Model (PQOM) continues to support the dynamic monitoring requirements of the Maternity Incentive Scheme (MIS) Year 8, providing oversight of safety, quality, workforce and operational performance across maternity and neonatal services through the use of Statistical Process Control (SPC) methodology. This approach enables the Trust to distinguish normal variation from true signals of improvement or deterioration, supporting timely identification of emerging risks, unwarranted variation and opportunities for learning and service improvement.

The dashboard includes data up to August 2026. Overall, many quality and safety indicators remain stable, with several areas demonstrating sustained positive performance. Notable strengths include 100% consultant attendance compliance, achievement of the 95% Maternity Support Worker night fill rate target, continued compliance with key maternity workforce standards, and stable performance in several clinical outcome measures. Registered Midwife night fill rates have also demonstrated a recent positive trend, indicating early signs of workforce improvement.

Workforce and operational pressures continue to be reflected across a number of indicators, with SPC analysis identifying some increasing variation in recent months. A range of capacity, flow and workforce measures remain sensitive to fluctuations in demand, acuity and resource availability, and will continue to be monitored through established governance arrangements to support service resilience and inform ongoing improvement activity.

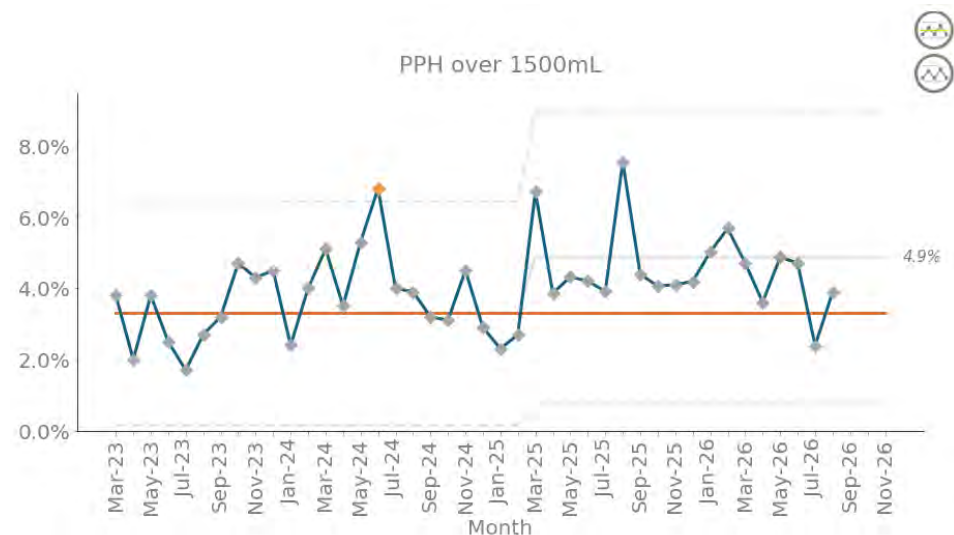
Clinical outcome measures remain broadly stable overall. Rates of Postpartum Haemorrhage (PPH $\geq 1500\text{ml}$) and Obstetric Anal Sphincter Injury (OASI) continue to demonstrate elevation within normal variation with no recent change, whilst APGAR scores below 7 at 5 minutes and delays in induction have shown increased variation and remain subject to ongoing review. Detailed analysis is included within the report for indicators demonstrating notable variation, emerging trends or targeted improvement activity, supporting oversight of performance, outcomes and quality improvement initiatives.

To support clear interpretation of performance, SPC analysis is used to categorise each metric according to one of four reporting themes: recent concerning variation or missed target; normal variation with performance on or around target; recent positive variation or achievement of target; and areas of high organisational interest that are routinely reported for assurance purposes irrespective of current performance. (Slide 4)

Dashboard 1 - Clinical Safety Indicators

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month target	Target rationale		
Clinical Safety indicators	Births			No Target Set			364.0	Aug-26
	Total stillbirths (number)			No Target Set			0.0	Aug-26
	Total stillbirths (rate per 1000 births)				3.2	National	0.0	Aug-26
	Stillbirth excluding TOPFA (number)			No Target Set			0.0	Aug-26
	Stillbirth excluding TOPFA (rate per 1000 births)			No Target Set			0.0	Aug-26
	Neonatal death within 28 days (number)			No Target Set			1.0	Aug-26
	Neonatal death within 28 days (rate per 1000 births)				6.0	National	2.7	Aug-26
	Booked <10				80.0%	Local	0.0%	Jul-26
	Booked <13				90.0%	Local	0.0%	Jul-26
	Induction of Labour rate			No Target Set			31.9%	Aug-26
	Women giving birth at obstetric unit			No Target Set			84.8%	Aug-26
	Women giving birth in a midwife-led setting			No Target Set			15.2%	Aug-26
	Home birth			No Target Set			2.5%	Aug-26
	APGAR score below 7 @5 minutes				1.2%	MBRRACE	3.3%	Aug-26
	PPH over 1500mL				3.3%	MBRRACE	3.9%	Aug-26
	Incidence of severe tears grade 3 and above				3.2%	MBRRACE	5.6%	Aug-26
	Breastfeeding initiation				81.0%	National	78.9%	Aug-26
	Confirmed HIE grade 2 or above (37 weeks +)			No Target Set			1.0	Aug-26

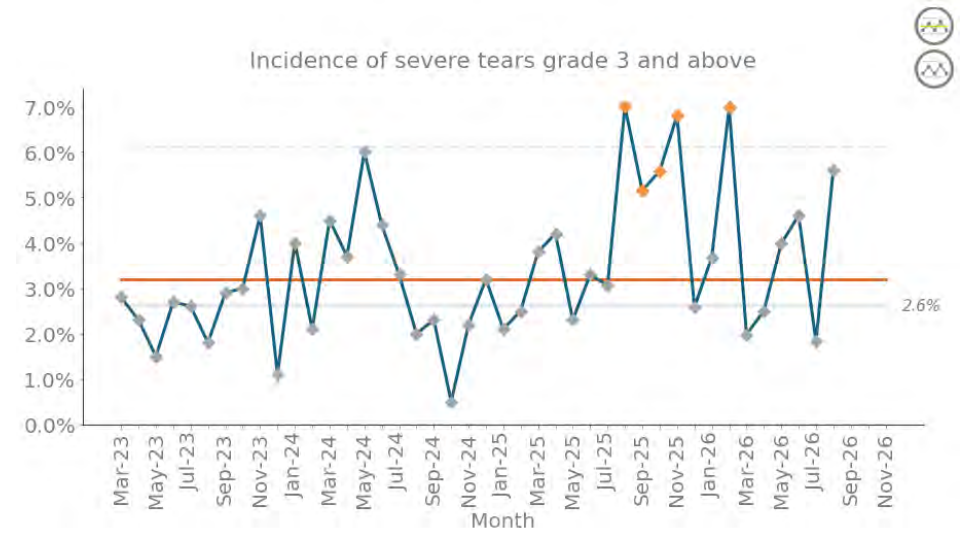
Assurance Report – Post Partum Haemorrhage (PPH)



Latest
3.8%
Variance Type
Normal Variation – no recent change
Target
3.3% (MBRRACE)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Post partum Haemorrhage (PPH) over 1500ml	Postpartum Haemorrhage (PPH) ≥ 1500ml continues to be monitored through established maternity governance and performance reporting arrangements. SPC analysis demonstrates normal variation with no recent change, with a latest reported rate of 3.8%, above the MBRRACE target of 3.3%. Improvement work continues through the established PPH Working Group and implementation of the Saving Babies' Lives Care Bundle Element 5 (Obstetric Haemorrhage), with a focus on cumulative blood loss measurement, earlier recognition of deterioration and timely intervention. Progress against some improvement actions has been slower than planned due to ongoing pressures within the obstetric workforce; however, the planned recruitment of additional consultant colleagues is expected to provide the capacity required to undertake a more detailed review of PPH performance and support further improvement activity.	- The PPH working group will continue to oversee the improvement programme and coordinate actions arising. (Noting that progress with this has been delayed by workforce pressures) - Training compliance for eligible staff groups will continue to be closely monitored to ensure sustained compliance with maternity emergency training compliance. - All cases of PPH ≥ 1500mls will continue to undergo audit and multidisciplinary review to identify learning opportunities and support continuous improvement. - Case based learning and targeted feedback will continue to be provided and embedded into education and learning sessions to strengthen learning from incidents.	- Performance relating to PPH ≥ 1500ml continues to be reviewed through monthly performance monitoring process (SPC). - Findings are collated and reported through quarterly governance reporting arrangements to provide organisational oversight. - All cases of PPH ≥ 1500mls undergo audit and multidisciplinary review to identify themes, learning opportunities and areas for improvement. - Established multiprofessional review processes provide ongoing assurance regarding the identification of risks, dissemination of learning and monitoring of improvement actions - Local performance will continue to be benchmarked against national maternity dashboard data to provide assurance regarding performance trends, identify unwarranted variation and support the evaluation of improvement initiatives

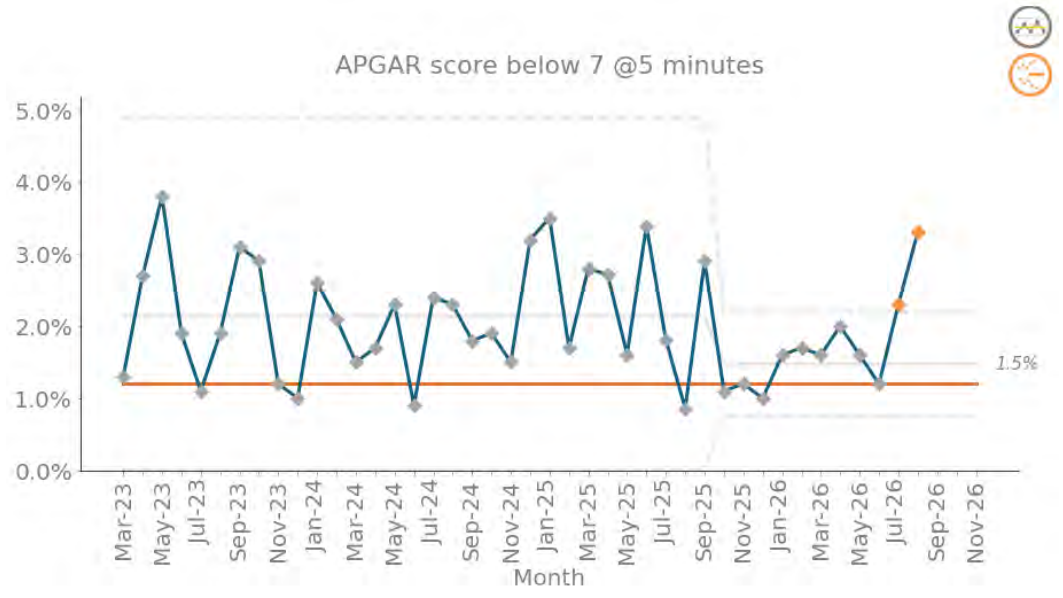
Assurance Report – Obstetric Anal Sphincter Injury (OASI)



Latest
5.6%
Variance Type
Normal Variation – no recent change
Target
3.2% (MBRRACE)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Incidence of severe tears grade 3 and above (Obstetric Anal Sphincter Injury OASI)	Severe perineal tears (Grade 3 and 4 OASI) continue to be monitored through established maternity governance and performance reporting arrangements. SPC analysis demonstrates normal variation with no recent change, with a latest reported rate of 5.6%, above the MBRRACE target of 3.2%. OASI rates are influenced by a range of factors including parity, birth complexity, fetal position, birthweight and operative vaginal birth, and therefore require ongoing review to identify opportunities for prevention and improvement. Whilst no direct causal relationship can be established, it is possible that reduced levels of previous operative obstetric experience may have contributed to the observed increase in instrumental births and associated third and fourth-degree perineal tears.	- Continue to monitor compliance with OASI Care Bundle training across all eligible staff groups. - Continue case-based learning and targeted feedback where elements of the OASI Care Bundle have not been fully implemented. - Increase education and training during induction and onboarding programmes for medical staff. From the August 2026 trainee rotation, clinical skills training will include OASI prevention and management, assisted birth techniques and episiotomy practice to strengthen competence and reduce variation in practice	- Performance relating to Grade 3 and 4 tears continues to be reviewed through monthly performance monitoring processes. - All cases of 3rd and 4th degree tears undergo audit and multidisciplinary review to identify themes, learning opportunities and areas for improvement. - Compliance with the OASI Care Bundle is reviewed through the established maternity governance framework, including reporting via the Maternity Safety and Quality Committee. - Training compliance is monitored routinely and remains above 90% across all eligible staff groups. - Local performance will continue to be benchmarked against national maternity dashboard data to provide assurance regarding performance trends, identify unwarranted variation and support the evaluation of improvement initiatives.

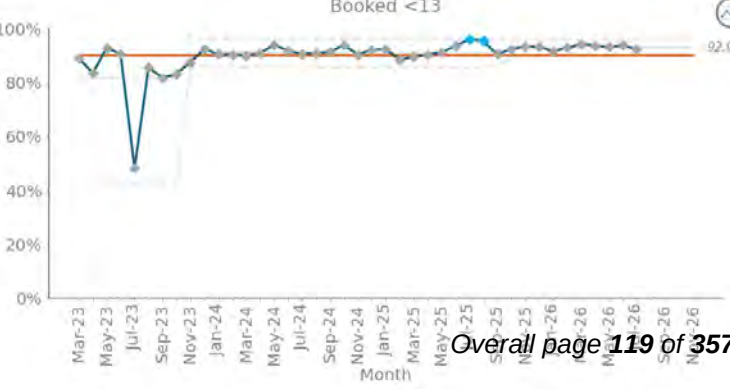
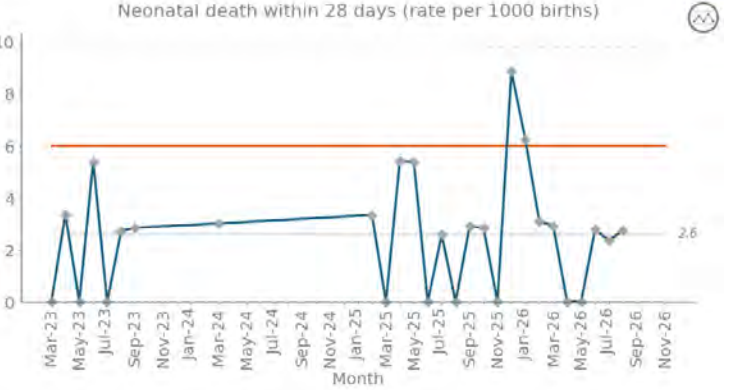
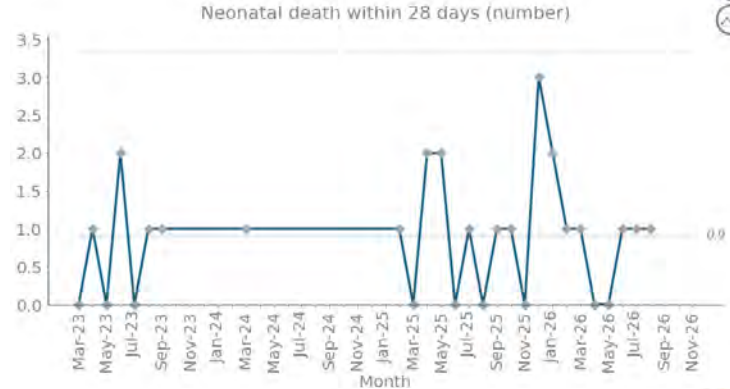
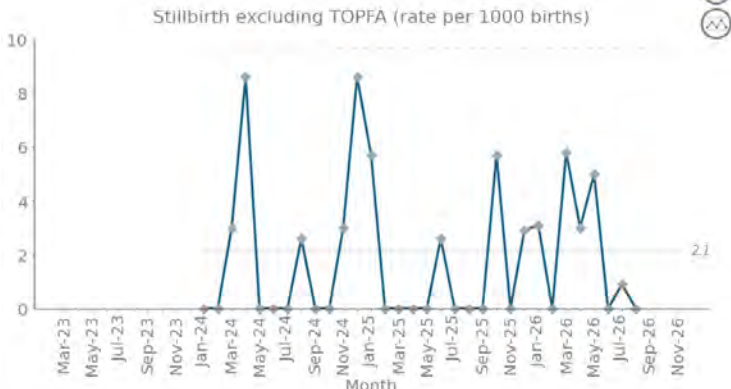
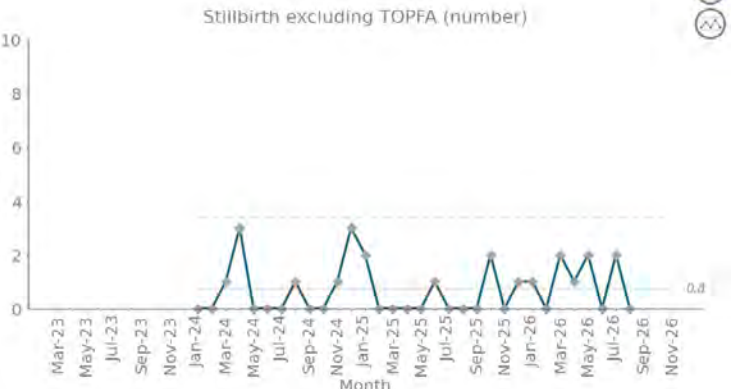
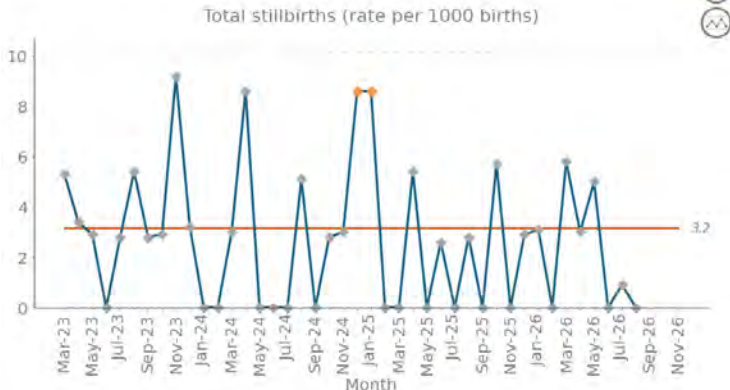
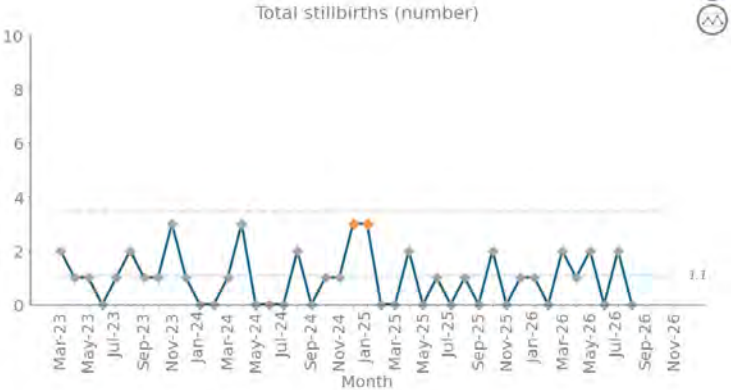
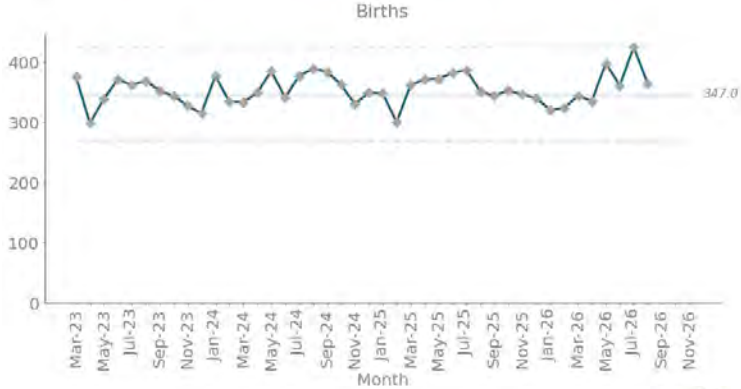
Assurance Report – APGAR



Latest
3.3%
Variance Type
Recent concerning pattern in the data
Target
1.2% (MBRRACE)
Target achievement
Could both pass or fail target within expected variation

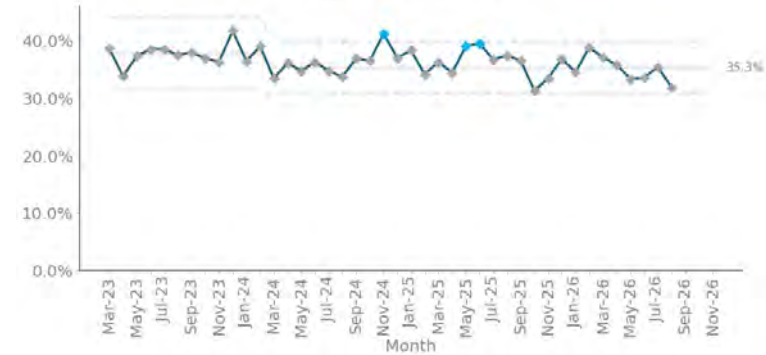
Metric	Summary	Actions	Assurance
APGAR score below 7 @ 5 minutes	Performance against Apgar scores below 7 at 5 minutes continues to be monitored through established maternity governance and performance reporting arrangements as a key indicator of neonatal condition following birth.SPC analysis has identified a recent concerning shift in performance, with the latest reported rate of 3.3%, exceeding both the MBRRACE target of 1.2% and the current process mean of 1.5%. Following a period of sustained improvement throughout 2025 and into early 2026, recent results suggest a deterioration beyond expected variation. While Apgar scores are influenced by a range of maternal, fetal and neonatal factors, this increase warrants ongoing scrutiny to better understand any contributory factors and identify opportunities for improvement. Importantly, triangulation of this data with other safety and outcome measures has not demonstrated a corresponding increase in severe neonatal harm or adverse outcomes. Whilst reassuring, continued monitoring will be required to determine whether this variation represents a sustained trend and to ensure any	- Continue to monitor APGAR scores below 7 at 5 minutes through monthly performance and quality review process. - Continue to promote learning from incident reviews, case discussions and multidisciplinary education forums to support improvements in intrapartum care. - Maintain compliance with mandatory maternity emergency training and neonatal resuscitation training programmes. - Continue to embed evidence-based intrapartum care practices and learning from local and national maternity safety initiatives	- SPC analysis demonstrates a recent concerning increase in APGAR scores below 7 at 5 minutes, with the latest result above the MBRRACE target. - Performance is routinely reviewed through established maternity governance arrangements to identify trends, monitor outcomes and support quality improvement activity.

Dashboard 1- Graphs

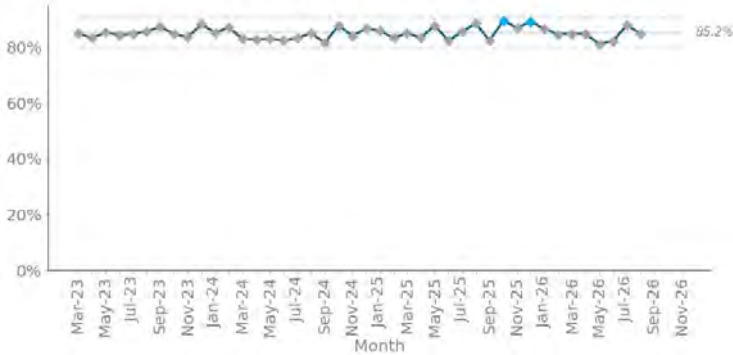


Dashboard 1- Graphs

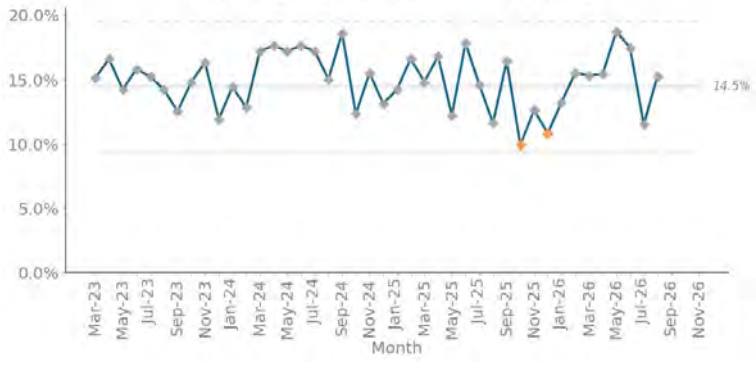
Induction of Labour rate



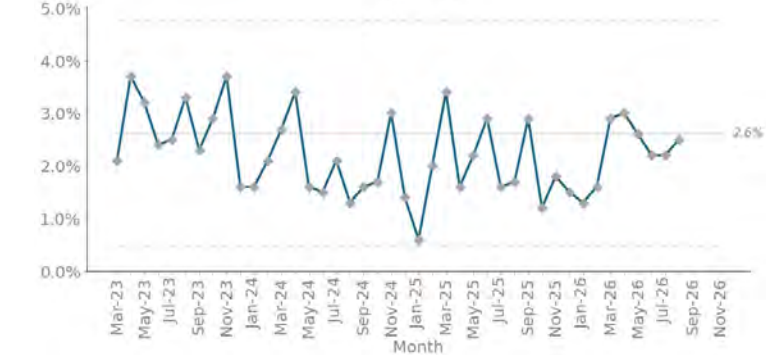
Women giving birth at obstetric unit



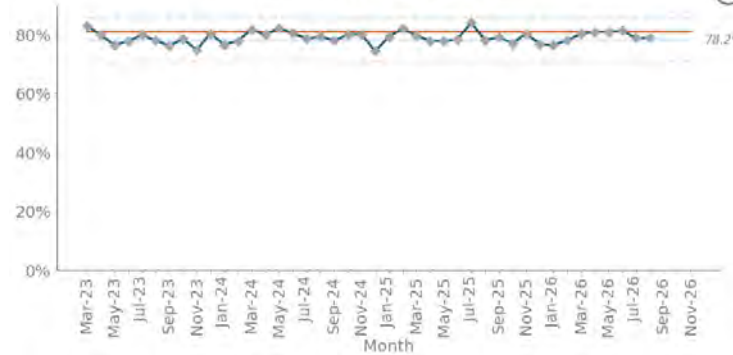
Women giving birth in a midwife-led setting



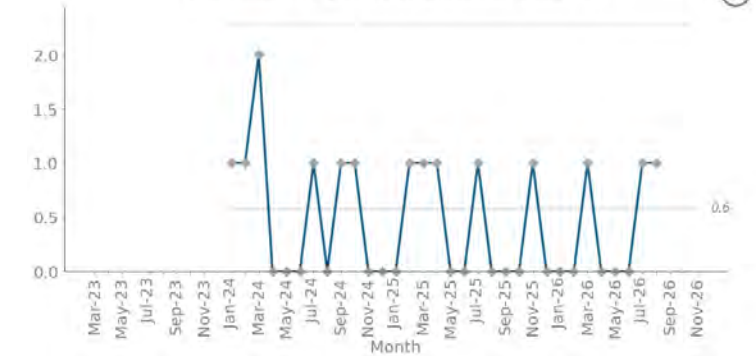
Home birth



Breastfeeding initiation

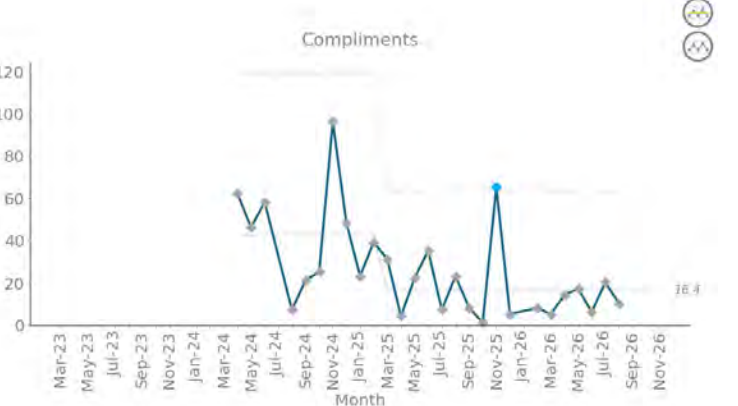
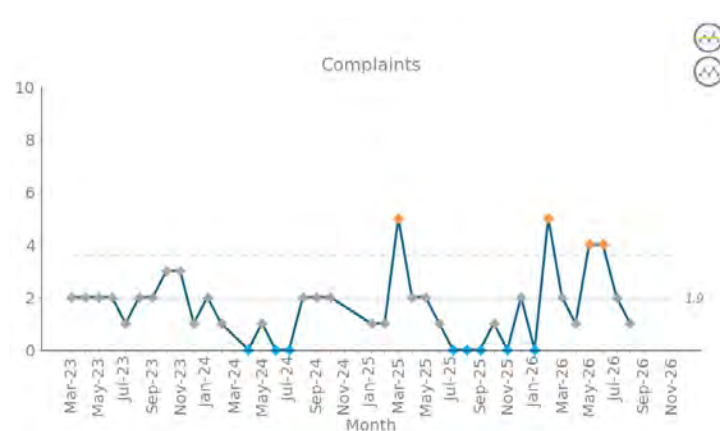
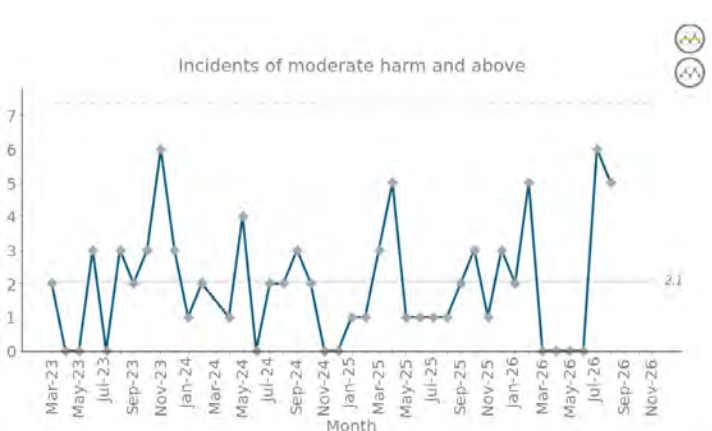
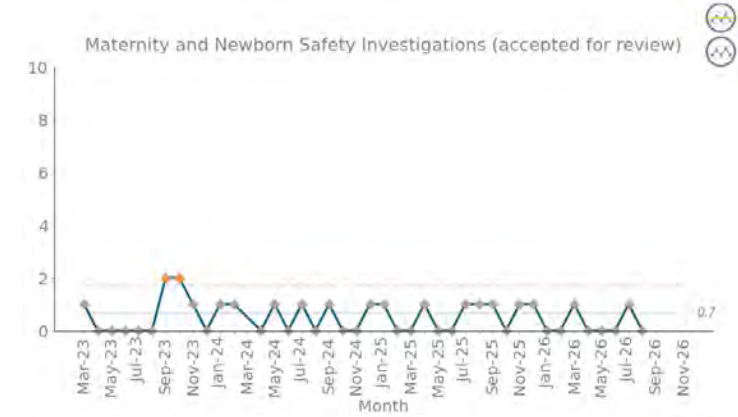
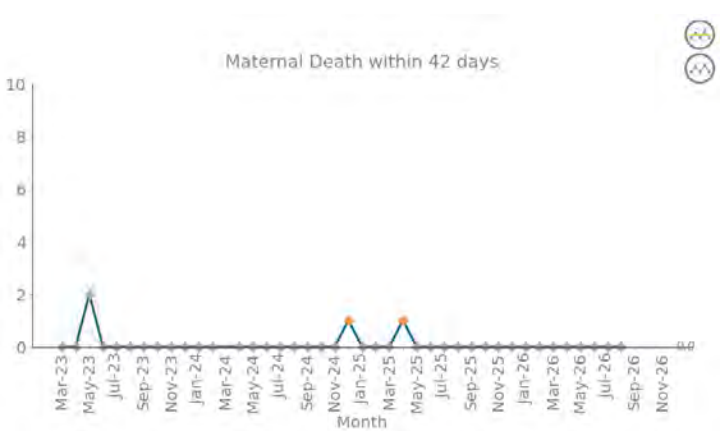
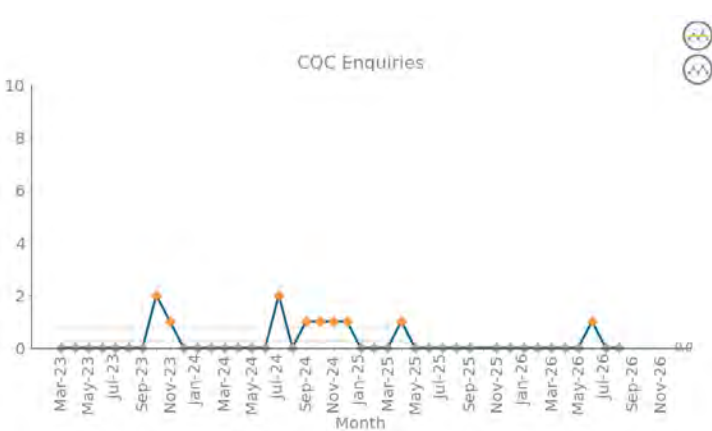
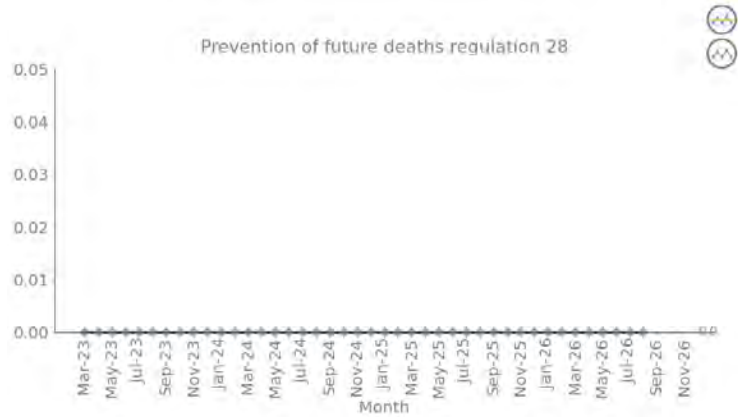


Confirmed HIE grade 2 or above (37 weeks +)



Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Perinatal Quality, Governance, Experience and Regulation	Prevention of future deaths regulation 28			No Target Set			0.0	Aug-26
	CQC Enquiries			No Target Set			0.0	Aug-26
	Maternal Death within 42 days			No Target Set			0.0	Aug-26
	Maternity and Newborn Safety Investigations (accepted for review)			No Target Set			0.0	Aug-26
	Incidents of moderate harm and above			No Target Set			5.0	Aug-26
	Complaints			No Target Set			1.0	Aug-26
	Compliments			No Target Set			10.0	Aug-26

Dashboard 2 - Graphs



Dashboard 3 – Safe Staffing indicators

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Safe Staffing Indicators	Births per Funded Clinical Midwife WTE			No Target Set			28.0	Aug-26
	Neonatal Nurse Staffing compliance to BAPM				90.0%	Local	82.0%	Aug-26
	Supernumerary status of DS coordinator at the start of every shift				100.0%	Local	100.0%	Aug-26
	HDU trained per shift				90.0%	Local	100.0%	Aug-26
	One-to-one care in labour in Delivery Suite				100.0%	Local	99.5%	Aug-26
	One-to-one care in labour in Preston Birth Centre				100.0%	Local	100.0%	Aug-26
	One-to-one care in labour in Chorley Birth Centre				100.0%	Local	100.0%	Aug-26
	Maternity Triage BSOT standard (15min)				80.0%	Local	84.9%	Aug-26
	Maternity Triage NICE standard (30 min)				90.0%	Local	94.1%	Aug-26
	Fill rate RM Day				95.0%	Trust	90.0%	Aug-26
	Fill rate MSW Day				95.0%	Trust	85.0%	Aug-26
	Fill rate RM Night				95.0%	Trust	87.0%	Aug-26
	Fill rate MSW Night				95.0%	Trust	95.0%	Aug-26
	Registered Midwife shifts sent to agency			No Target Set			0.0	Aug-26
	Registered Midwife Agency hour fill rate percentage			No Target Set			0.0%	Aug-26
	Staff sickness rate				5.2%	Trust	8.3%	Aug-26

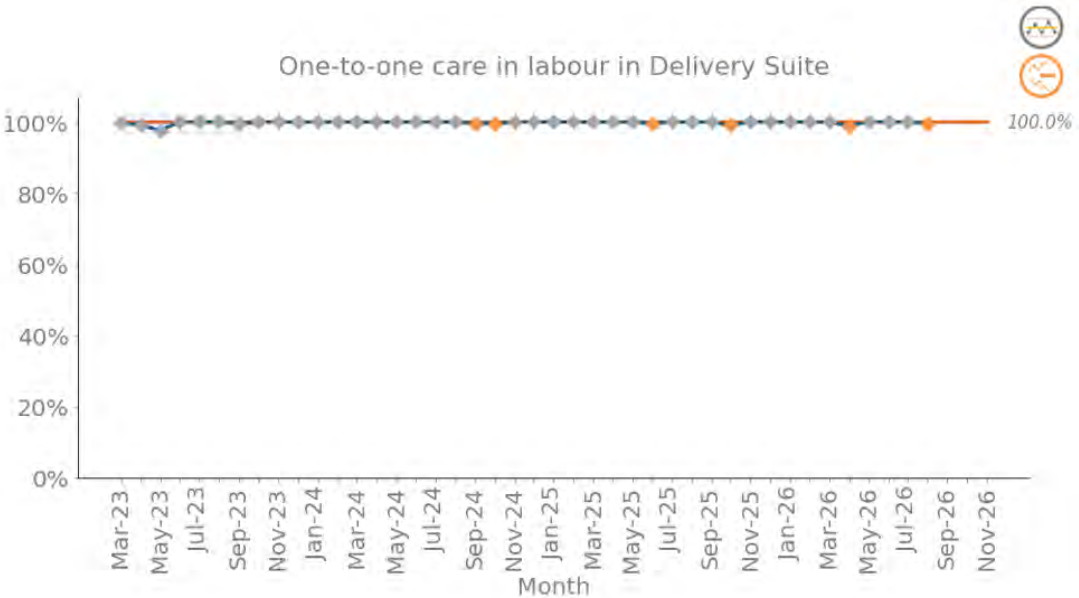
HDU trained per shift

93.2%

Month	Blue Line (%)	Grey Line (%)
Mar-23	100	100
May-23	100	100
Jul-23	100	100
Sep-23	100	100
Nov-23	98	100
Jan-24	98	100
Mar-24	100	100
May-24	98	100
Jul-24	98	100
Sep-24	98	100
Nov-24	92	100
Jan-25	95	100
Mar-25	92	100
May-25	98	100
Jul-25	95	100
Sep-25	95	100
Nov-25	92	100
Jan-26	90	100
Mar-26	100	100
May-26	100	100
Jul-26	100	100
Sep-26	100	100
Nov-26	100	100

Metric	Summary	Actions	Assurance
HDU trained per shift	Compliance with HDU-trained staffing has remained above the Trust target of 90% throughout the reporting period. Performance has improved in recent months, with sustained achievement of 100% compliance. Variation has reduced and there is a positive upward trend demonstrating improved workforce capability and resilience.	• Continue monitoring compliance through monthly workforce reporting. • Maintain HDU training uptake and competency updates for existing staff. • Ensure newly appointed staff are booked onto HDU training at the earliest opportunity. • Review training requirements proactively to maintain establishment and succession planning.	High level of assurance. The metric has consistently exceeded the Trust target, with the latest performance at 100%. Sustained achievement above target and a positive trend indicate appropriate staffing capability to provide safe care within the maternity HDU environment. Ongoing monitoring and training plans are in place to maintain performance.

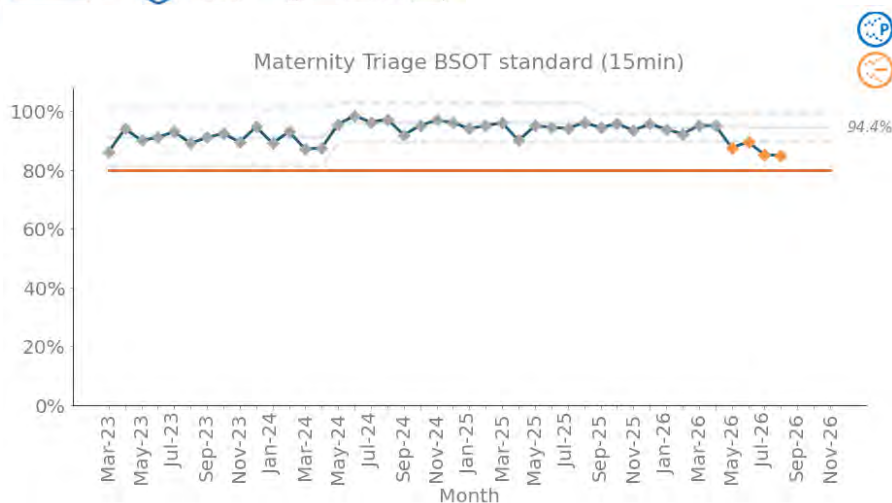
Assurance Report – One to one care in delivery suite



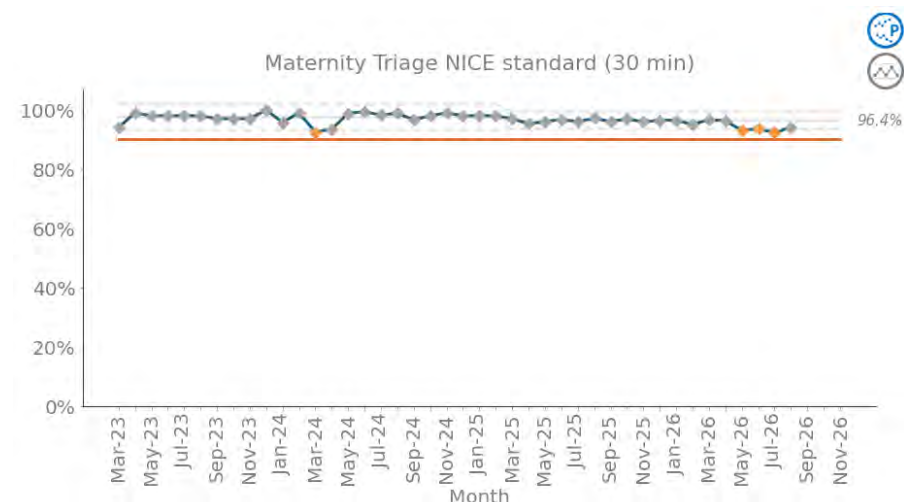
Latest
99.5%
Variance Type
Recent concerning pattern in the data
Target
100% (Trust)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
One to one care in delivery suite	One-to-one care in labour has remained consistently high throughout the reporting period, with performance generally close to the Trust target of 100%. The latest reported compliance is 99.5%. Whilst there has been a recent concerning pattern identified within the data, overall compliance remains strong with only a small number of occasions where one-to-one care could not be achieved.	- Continue monthly review of one-to-one care compliance. - Review occasions where one-to-one care was not achieved to identify themes and learning. - Monitor staffing escalation and workforce pressures that may affect compliance. - Maintain workforce planning and recruitment initiatives to support safe staffing levels.	Moderate to high assurance. Compliance remains consistently high and close to the Trust target; however, the recent concerning pattern requires continued oversight. Current monitoring processes provide assurance that any deterioration in performance will be identified and addressed promptly.

Assurance Report – Triage Standards

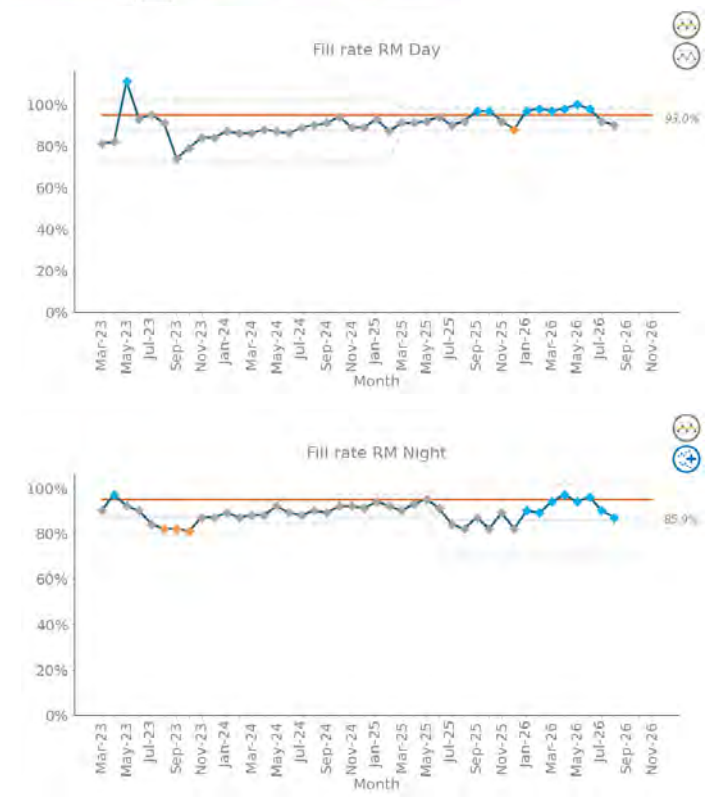


Latest
84.9%
Variance Type
Recent concerning pattern in the data
Target
80.0% (Local)
Target achievement
Will consistently pass target within standard variation



Latest
94.1%
Variance Type
Normal variation –no recent change
Target
90.0% (Local)
Target achievement
Will consistently pass target within standard variation

Metric	Summary	Actions	Assurance
Maternity Triage BSOT standard (15min)	Performance against the BSOTS 15-minute triage standard continues to be monitored through established operational and governance processes. SPC analysis demonstrates a recent reduction in performance, with compliance at 84.9%; however, performance remains above the local target of 80%. Workforce pressures associated with sickness absence, rota gaps and recruitment challenges have impacted assessment timeliness within the Maternity Assessment Suite.	- Continue recruitment activity in support of the approved Two-Tier Obstetric Business Case. - Progress recruitment to the additional 5.51 WTE establishment for the Maternity Assessment Suite, supporting the implementation of a dedicated telephone triage and call-handling system. - Continue recruitment to Band 5 and Band 6 vacancies to strengthen workforce capacity and resilience. - Progress recruitment to the additional 1.0 WTE Day Unit post to ensure planned activity can be fully delivered within the antenatal clinic footprint.	- Performance against the BSOTS 15-minute triage/30-minute NICE standard continues to be reviewed through established operational, performance and governance arrangements. - The service maintains oversight of workforce capacity, sickness absence and rota gaps to understand the impact on service delivery and patient flow within the Maternity Assessment Suite. - Recruitment progress associated with the Two-Tier Obstetric Business Case and Birth Rate Plus (BR+) investment is regularly monitored through divisional governance processes.
Maternity Triage NICE standard (30min)	Performance against the NICE 30-minute triage standard remains stable at 94.1%, consistently exceeding the local target of 90%. SPC analysis demonstrates normal variation with no recent significant change in performance.	- Continue delivery of workforce improvements associated with the Birth Rate Plus (BR+) investment programme. - Monitor performance against the BSOTS 15-minute standard through routine operational and governance review processes to assess the impact of workforce interventions - Benchmarking with the new national framework has been undertaken and this is being presented to the Trust board	Whilst performance has reduced, compliance remains above the local target, providing assurance that the standard continues to be achieved.



Assurance Report – Fill rate

Latest
90.0%
Variance Type
Normal Variation – no recent change
Target
95.0% (Trust)
Target achievement
Could both pass or fail target within expected variation



Latest
85.0%
Variance Type
Normal Variation – no recent change
Target
95.0% (Trust)
Target achievement
Will consistently fail target within expected variation

Latest
95.0%
Variance Type
Normal Variation – no recent change
Target
95.0% (Trust)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Fill rate RM Day	Fill rate is 90.0%, below the Trust target of 95%. SPC demonstrates normal variation with no recent change, consistently close to, but below, target.	1. Recruitment to the additional 5.51 WTE Maternity Assessment Suite establishment is underway to support implementation of a dedicated telephone triage and call-handling system. 2. Recruitment is also progressing for the 1 WTE Day Unit post, approved BR+ investment posts, and Maternity Support Worker vacancies, including Band 5/6 roles. 3. MSW Night shifts are prioritised for cover due to the increased risk at night, with the ability to flex staff further during the day to cover shortfalls. 4. Focus remains on recruitment and retention initiatives, monitoring roster performance and temporary staffing usage to sustain improvement	1. The fill rates remains stable with no evidence of deterioration. 2. Recruitment activity is expected to improve staffing resilience and support future improvement in fill rates, although achievement of the 95% target cannot currently be assured. 3. Recent recruitment to 13.4 WTE Midwives and further recruitment is in progress. Recent improvement provides some assurance that actions are having a positive impact. 4. MSW presence on the ward is a service priority; with only 2 MSW shifts per day, each unfilled shift significantly reduces the reported fill rate.
Fill rate RM Night	Fill rate is 90.0%, below the Trust target of 95%. SPC demonstrates normal variation with no recent change, consistently close to, but below, target.		
Fill rate MSW Day	Fill rate is 85.0%, below the Trust target of 95%. SPC demonstrates normal variation with no recent change, consistently below target.		
Fill rate MSW Night	Fill rate is 95.0%, meeting the Trust target. SPC demonstrates normal variation, indicating a stable and capable process.		

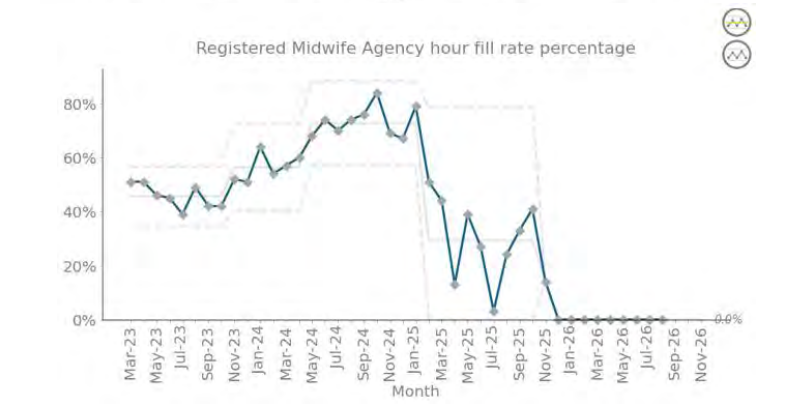
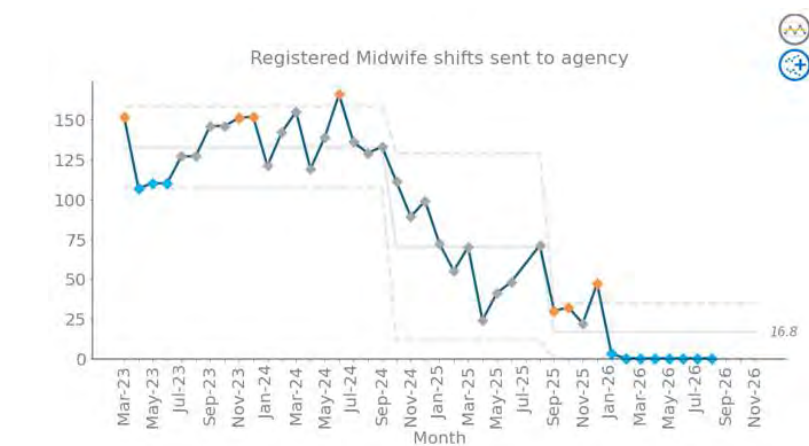
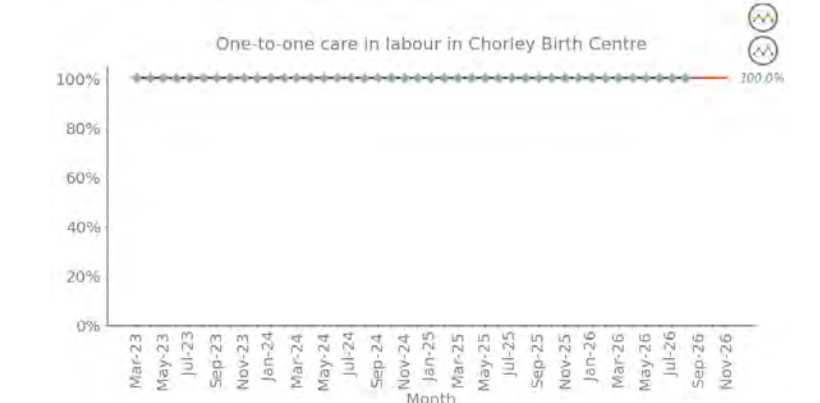
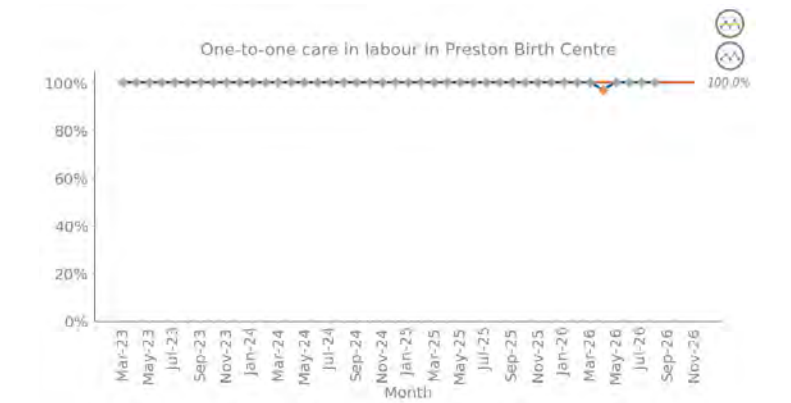
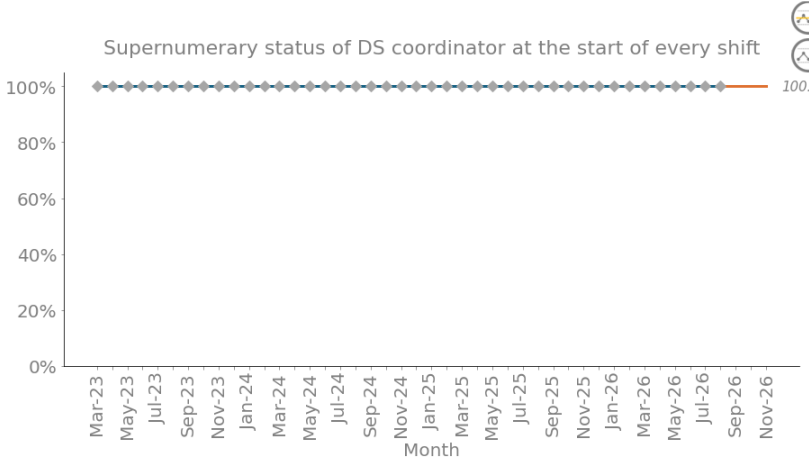
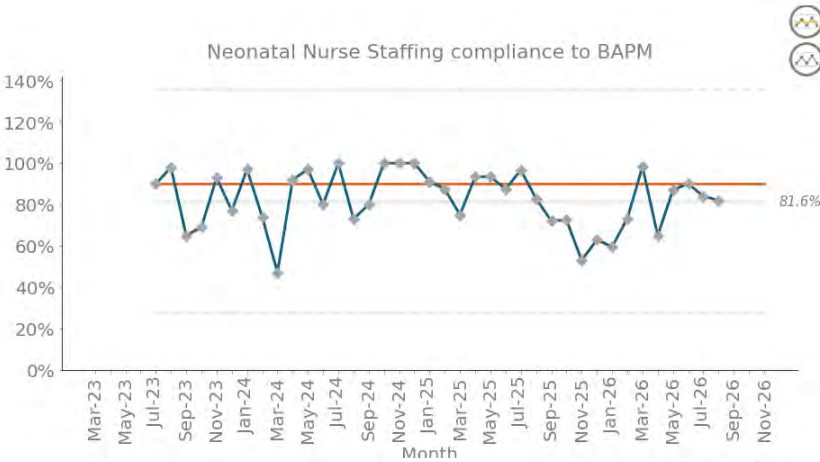
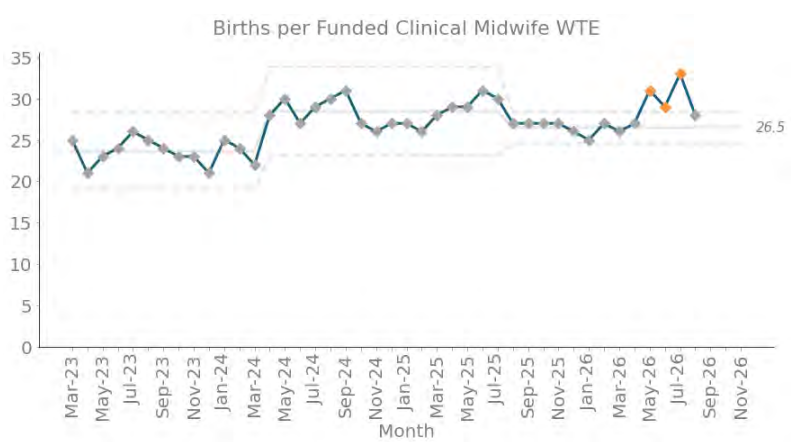
Assurance Report – Sickness



Latest
8.3%
Variance Type
Recent concerning pattern in the data
Target
5.2% (Trust)
Target achievement
Could both pass or fail target within expected variation

Metric	Summary	Actions	Assurance
Sickness	Staff sickness is currently 8.3%, above the Trust target of 5.2%. SPC analysis demonstrates a recent concerning pattern in the data, with sickness absence increasing in recent months following a period of improvement earlier in 2026. Whilst May 2026 recorded the lowest level of sickness absence during the reporting period, recent results indicate deterioration above expected levels of variation. Continued focus is required to understand contributory factors and reduce workforce absence.	- Monthly workforce assurance meetings will continue to provide oversight of workforce performance, staffing risks and delivery of workforce improvement plans. - Targeted workforce reviews will be undertaken in areas demonstrating elevated sickness absence or sustained long-term absence to identify contributory factors, support staff wellbeing and implement appropriate interventions. - Continue monitoring sickness absence trends alongside staffing, quality and operational performance metrics to assess the impact of workforce attendance on service resilience. - Continue implementation of health, wellbeing and attendance support initiatives to sustain improvements in workforce attendance and reduce the likelihood of future increases in sickness absence	- SPC analysis demonstrates a sustained improvement in sickness absence performance since October 2025 However, recent results indicate a decline in performance. - Sickness absence data is monitored alongside staffing, patient safety, quality and operational performance indicators to provide assurance regarding the impact of workforce attendance on service delivery. - Established workforce planning, escalation and wellbeing processes remain in place to support staff attendance, maintain safe staffing levels and mitigate risks associated with workforce pressures.

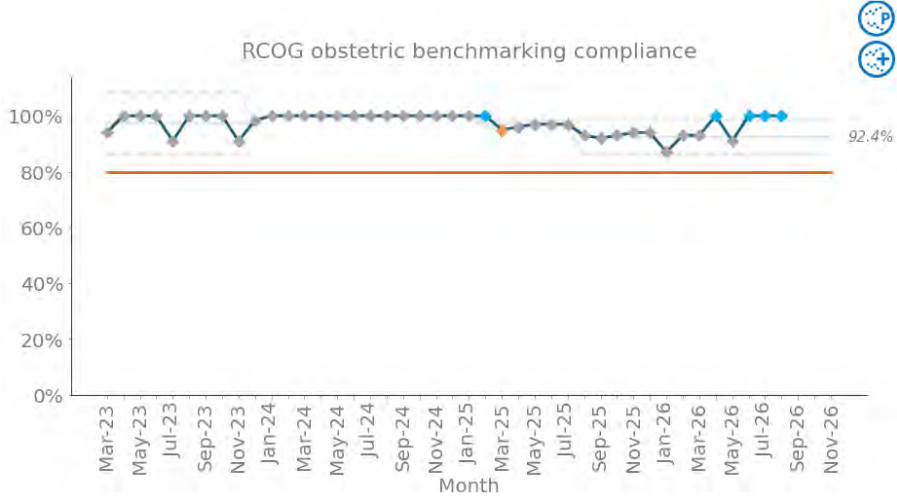
Dashboard 3 - Graphs



Dashboard 4 – Obstetric Medical Staffing

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Obstetric Medical Staffing	Number of Consultant hours on obstetric unit			No Target Set			90.0	Aug-26
	RCOG obstetric benchmarking compliance				80.0%	(MIS Year 7)	100.0%	Aug-26
	24-hour acute obstetric medical staffing fill rate				100.0%	Local	100.0%	Aug-26

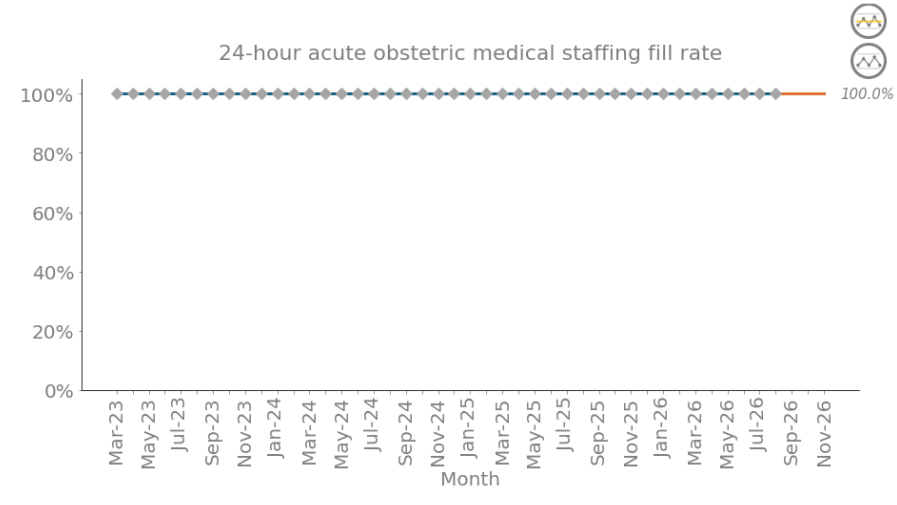
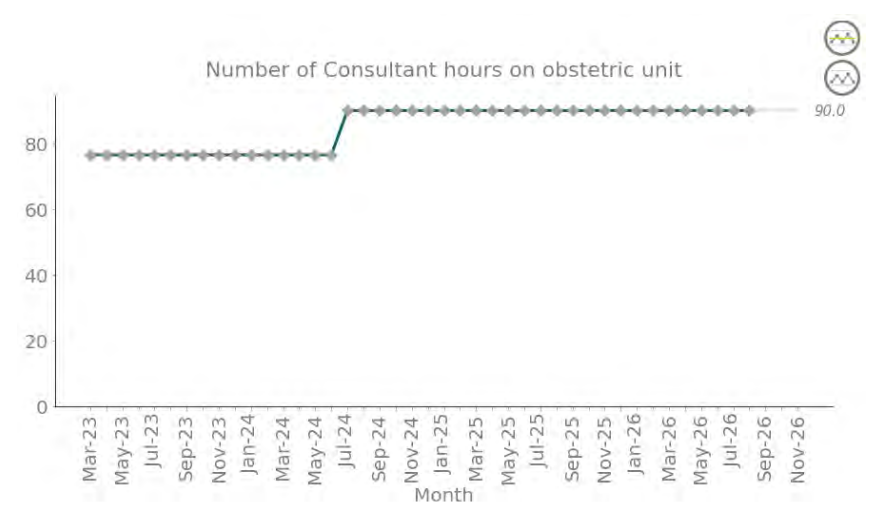
Assurance Report – RCOG Compliance



Latest
100.0%
Variance Type
Recent positive pattern in the data
Target
80.0% (MIS Year 7)
Target achievement
Will consistently pass target within expected variation

Metric	Summary	Actions	Assurance
RCOG consultant attendance obstetric benchmarking compliance	RCOG consultant attendance compliance is monitored in line with Royal College of Obstetricians and Gynaecologists (RCOG) workforce standards and supports delivery of the Maternity Incentive Scheme (MIS) Year 8 requirements relating to workforce capacity and safe clinical care. SPC analysis demonstrates a recent positive pattern in the data, with compliance improving above expected variation and the latest performance at 100%, exceeding the locally agreed target of 80%. This provides assurance that women are receiving timely access to senior obstetric review when required and reflects sustained compliance with RCOG workforce standards. Although MIS Year 8 no longer specifies a national percentage threshold for consultant attendance, organisations are required to demonstrate effective monitoring, governance and assurance arrangements. A local target of 80% has therefore been applied	- Continue to monitor consultant attendance against RCOG workforce standards through established performance and governance arrangements. - Review any episodes of non-compliance or variation and implementation improvement actions where required. - Continue workforce planning and recruitment initiatives to support sustainable consultant workforce capacity and resilience. - Utilise consultant attendance data to inform service improvement, workforce planning and compliance with Maternity Incentive Scheme requirements	- Consultant attendance is routinely monitored through established maternity governance and performance reporting arrangements in line with RCOG workforce standards. - Recent SPC analysis demonstrates improved compliance with consultant attendance requirements, providing assurance that women are receiving timely access to senior obstetric review when required. - Performance is reviewed as part of the organisation's Maternity Incentive Scheme assurance framework, supporting oversight of workforce capacity, clinical safety and quality of care.

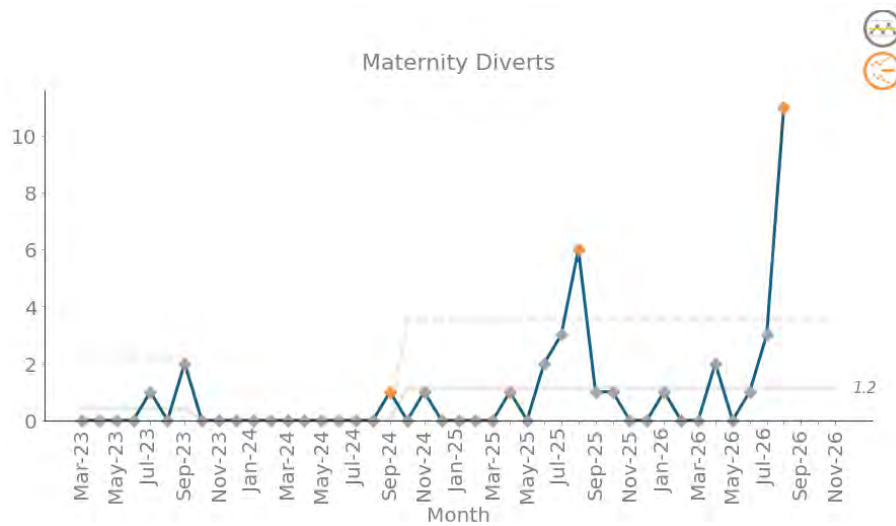
Dashboard 4 - Graphs



Dashboard 5 – Clinical Escalation

Metric Description		Assurance	Variation	Target			Latest actual month	Latest month
				Concern	Latest month	Target rationale		
Clinical Escalation	Maternity Diverts				No Target Set		11.0	Aug-26
	Number of times home birth service stood down				No Target Set		2.0	Aug-26
	Women who transfer to an alternative provider during induction of labour				No Target Set		0.0	Aug-26
	In- utero transfers declined to accept from other units (maternity)				No Target Set		2.0	Aug-26
	In- utero transfers declined to accept from other units (NICU)				No Target Set		2.0	Aug-26
	In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)				No Target Set		0.0	Aug-26
	NICU Closure				No Target Set		3.0	Aug-26
	Delay in inductions				No Target Set		122.0	Aug-26
	Elective sections stood down				No Target Set		10.0	Aug-26

Assurance Report – Maternity Diverts

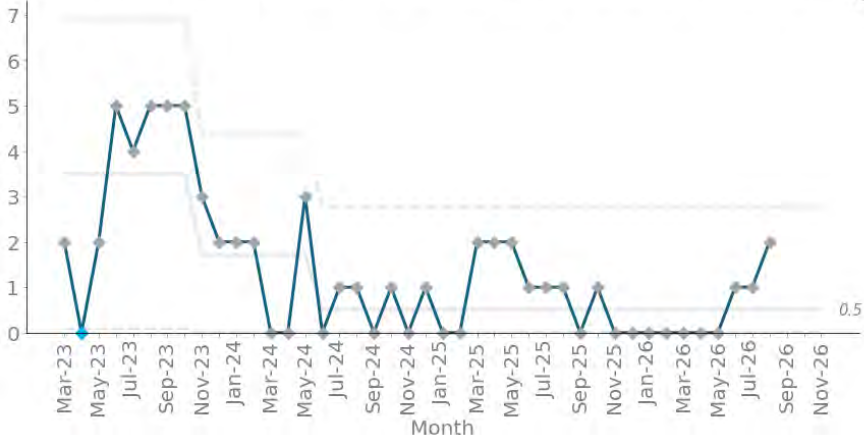


Latest
11
Variance Type
Recent pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
Maternity divers	Maternity divers remain an infrequent event; however, SPC analysis demonstrates a recent concerning month in the data. Following a prolonged period of low levels of divers, performance has shown increased variation since mid-2025, with the latest reported position of 11 divers representing the highest level during the reporting period and exceeding expected variation. Divers are closely linked to surges in demand, capacity constraints and staffing pressures, and therefore require continued review to identify contributory factors and opportunities for improvement. A balance must be struck when reviewing divers. It is right that the service escalates and seeks system support when demand exceeds safe capacity; equally, the disruption and transfer of care involved in a divert can have a significant impact on women and their families, and this must be weighed in every decision.	- Continue to monitor maternity divers through established maternity governance, capacity and flow meetings. - Review each divert episode to identify themes, contributory factors and opportunities to reduce future occurrences. - Continue workforce, capacity and escalation planning to support safe patient flow and maintain service provision during periods of increased demand. - Monitor the impact of ongoing recruitment and workforce improvement initiatives on capacity, staffing resilience and divert activity.	- SPC analysis demonstrates a recent concerning increase in maternity divers, with the latest result indicating performance outside expected variation. - All divert episodes are monitored through established governance processes to assess impact on patient safety, service delivery and operational performance. - Escalation, capacity management and workforce planning processes remain in place to support safe care delivery and mitigate risks associated with periods of increased demand and reduced capacity.

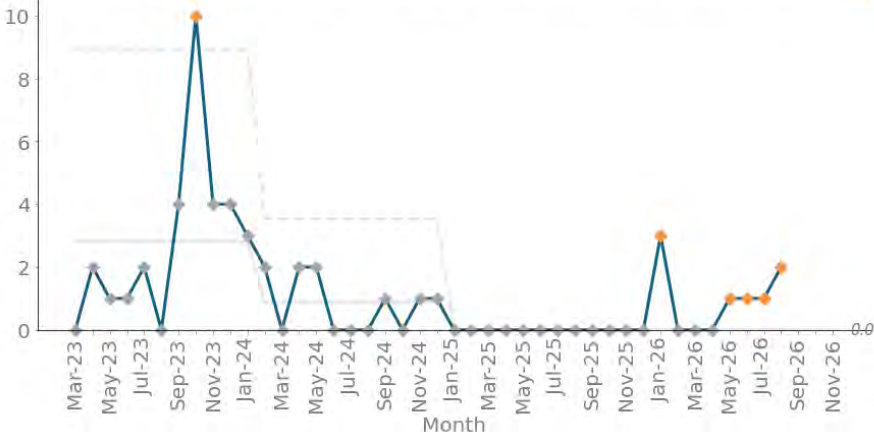
Assurance Report – Transfers Declined

In- utero transfers declined to accept from other units (maternity)



Latest
2
Variance Type
Normal Variation – no recent change
Target
No Target Set
Target achievement
No Target Set

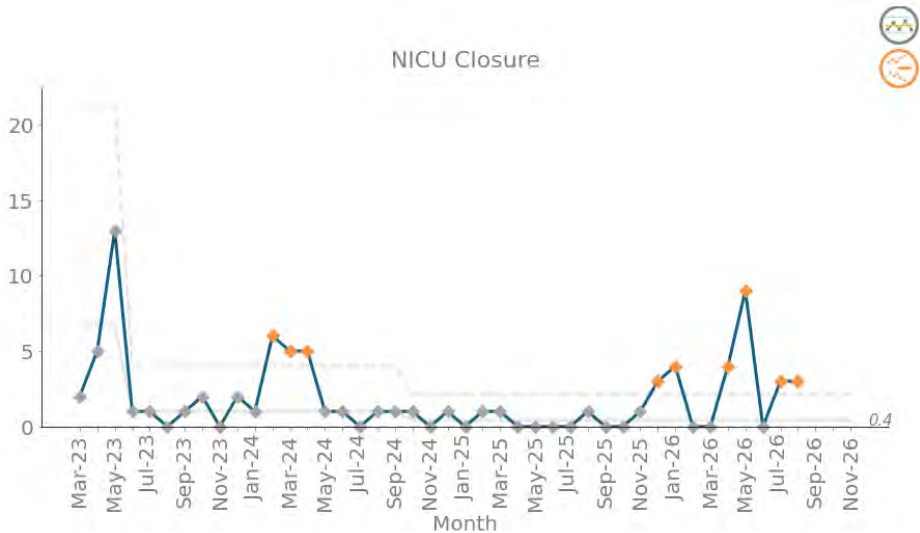
In- utero transfers declined to accept from other units (NICU)



Latest
2
Variance Type
Recent pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
In –utero transfers declined to accept from other units (NICU)	In-utero transfers declined from other units continue to be monitored through established operational and governance arrangements. SPC analysis demonstrates normal variation with no recent change, with the latest reported position of 2 declined transfers. Although there has been month-to-month variation across the reporting period, the overall process remains stable and declined transfers remain relatively infrequent events. Demand, capacity, acuity and workforce availability continue to influence the unit's ability to accept transfer requests. Whilst this variation is noted, assurance is provided that decisions to decline transfers were made through established operational and clinical management processes, with patient safety, safe staffing and the maintenance of safe standards of care remaining the primary considerations	- Continue routine monitoring of transfer requests, capacity, acuity and workforce availability through established operational processes. - Continue recruitment and retention initiatives to address workforce vacancies and improve staffing resilience within neonatal services. - Utilise escalation processes and workforce management arrangements to mitigate the impact of sickness absence and short-term staffing pressures. - Continue biannual safe staffing reviews with the Chief Nursing Officer aligned to National Quality Board (NQB) requirements.	- All decisions to decline transfers are made through established clinical and operational management processes, with patient safety and safe staffing remaining the overriding considerations. - Transfer activity, cot capacity, workforce availability and demand are routinely reviewed through neonatal operational network and governance arrangements to provide oversight of service resilience and risk. - Workforce metrics, including vacancies and sickness absence, are monitored alongside neonatal activity and capacity data to understand factors influencing transfer acceptance.

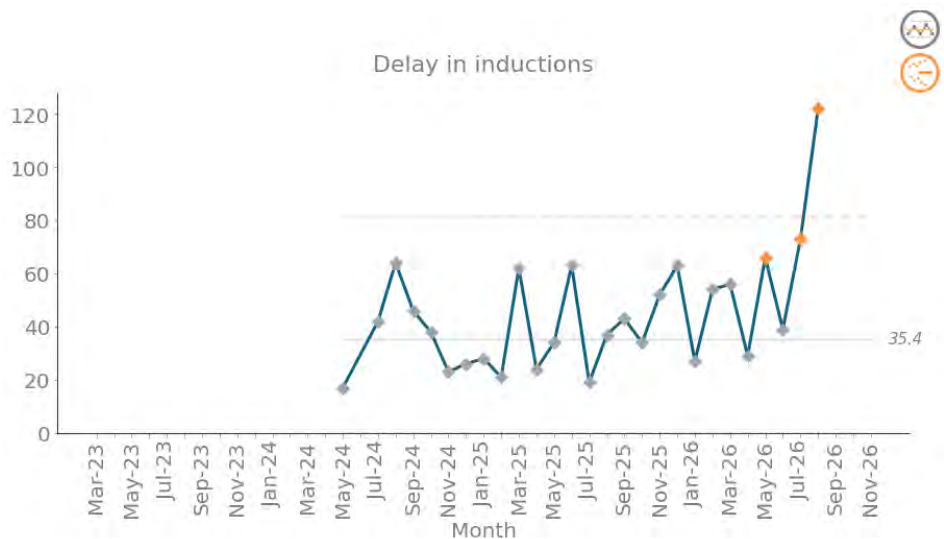
Assurance Report – NICU Closure



Latest
3
Variance Type
Recent pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
NICU Closure	NICU closures continue to be monitored through established neonatal governance and capacity management arrangements. SPC analysis demonstrates a recent pattern in the data, with the latest position of 3 closures and a number of recent months showing closure activity above expected variation. Closure activity is influenced by a combination of neonatal cot capacity, workforce availability, acuity and demand from babies requiring intensive or specialist neonatal care. Whilst variation has increased in recent months, closure episodes continue to be reviewed to understand contributory factors and identify opportunities to improve service resilience.	- Continue oversight of Transitional Care capacity by monitoring occasions where provision is impacted by BAPM staffing requirements, ensuring opportunities to reduce avoidable neonatal admissions are identified. - Re-establish the Transitional Care Working Group to provide dedicated oversight of capacity, workforce, pathway development and quality improvement initiatives aimed at supporting mothers and babies to remain together wherever clinically appropriate. - Continue to review workforce capacity, staffing resilience and demand management arrangements to support sustained improvements in neonatal service availability. - Monitor the impact of improvement actions on NICU closure rates, BAPM compliance and patient flow across neonatal service	- SPC analysis demonstrates a recent upward pattern in NICU closure activity, requiring continued monitoring and review. - NICU closures, neonatal capacity, workforce metrics and demand are routinely reviewed through established neonatal governance processes to provide oversight of service resilience and risk. - Escalation, capacity management and workforce planning arrangements remain in place to support safe care delivery and mitigate risks associated with periods of increased demand, acuity and reduced capacity. - Local performance will continue to be reviewed alongside regional and national benchmarking information where available to identify variation, support learning and evaluate the effectiveness of improvement initiatives.

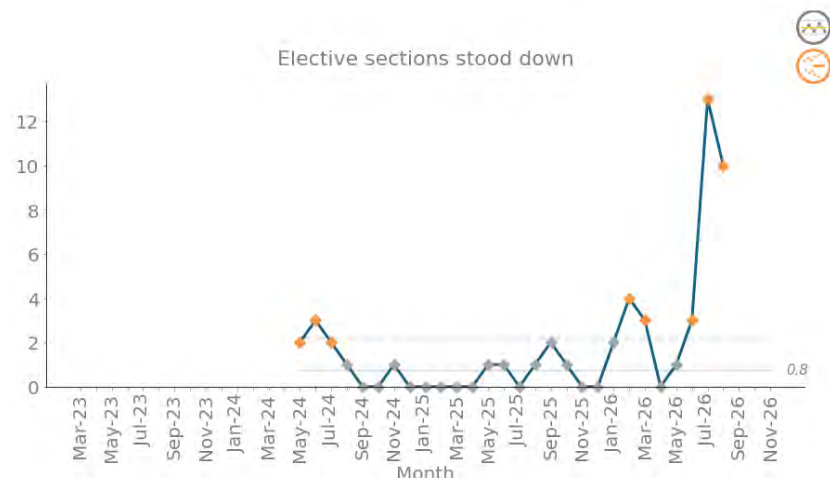
Assurance Report – Delay in Inductions



Latest
122
Variance Type
Recent concerning pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
Delay in inductions	Delays in induction of labour continue to be monitored through established maternity governance and operational management arrangements. SPC analysis demonstrates a recent concerning pattern in the data, with the latest reported position of 122 delays, representing the highest level during the reporting period and exceeding expected variation. Delays are influenced by a combination of maternity capacity, workforce availability, clinical acuity and demand for delivery suite and inpatient beds. The recent increase indicates sustained operational pressures, triangulates with increase number of diverts and requires continued focus on improving patient flow and capacity management.	- Continue monitoring induction delays through established maternity governance, capacity and flow meetings. - Review contributory factors associated with delays, including workforce capacity, bed availability, clinical acuity and demand, and implement improvement actions where required. - Continue recruitment, retention and workforce planning initiatives to improve staffing resilience and support delivery suite capacity. - Strengthen patient flow, escalation and capacity management processes to minimise delays and support timely induction of labour.	- SPC analysis demonstrates a recent concerning increase in induction delays, with the latest result exceeding expected variation. - Induction delays are routinely reviewed alongside activity, capacity, staffing and patient flow metrics through established maternity governance arrangements to understand impact on service delivery and patient experience. - Escalation, capacity management and workforce planning processes remain in place to support safe care delivery, manage periods of increased demand and mitigate risks associated with operational pressures.

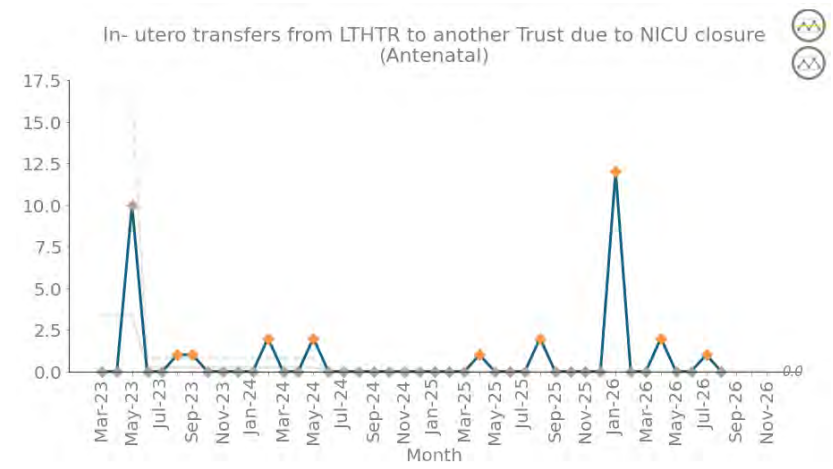
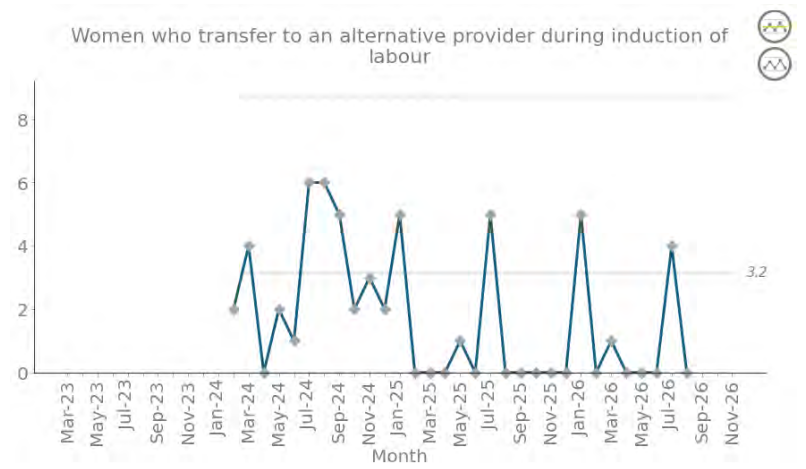
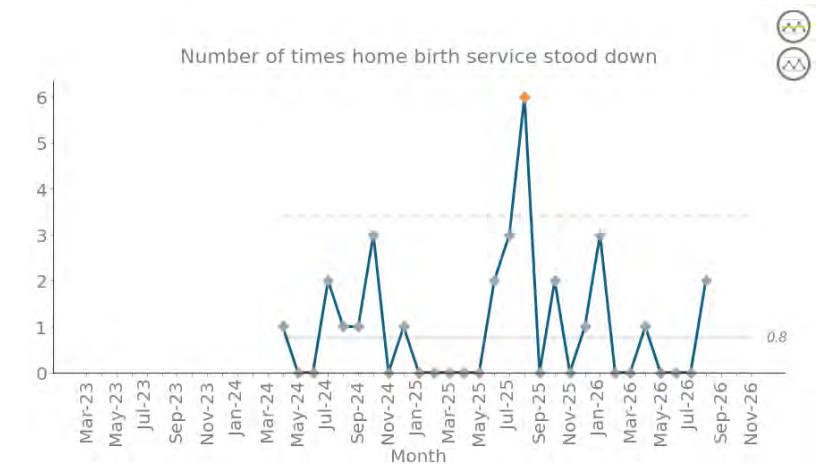
Assurance Report – Elective Caesarean sections stood down



Latest
10
Variance Type
Recent concerning pattern in the data
Target
No Target Set
Target achievement
No Target Set

Metric	Summary	Actions	Assurance
Elective sections stood down	Elective caesarean sections stood down continue to be monitored through established operational and governance arrangements. SPC analysis demonstrates a recent concerning pattern in the data, with the latest reported position of 10 stood down procedures, following a sustained increase in recent months and variation above expected levels. This reflects ongoing pressure on theatre capacity, workforce availability, maternity activity and emergency clinical demand, resulting in reduced availability for elective activity. Continued focus is required to understand contributory factors and improve elective theatre utilisation and patient flow. A comprehensive capacity and demand review is currently underway to better understand activity levels, utilisation patterns and opportunities for improvement In parallel, actions are being implemented to strengthen booking and scheduling processes, ensuring theatre allocation is aligned more effectively with case complexity and anticipated procedure duration. Further assurance is provided through the planned opening of a fourth theatre within the Sharoe Green Unit, which is expected to improve capacity, patient flow and overall operational resilience and is planned to be open by 01 November 26.	- Weekly multidisciplinary theatre scheduling meetings will continue to optimise elective caesarean section capacity, improve theatre utilisation and support a reduction in procedure stand downs. - A revised booking and scheduling approach is being implemented within antenatal clinic services to align theatre allocation more effectively with the complexity and anticipated duration of individual cases. - The OG4 mobilisation programme will continue to be progressed through fortnightly meetings to ensure operational, workforce and quality requirements are delivered in preparation for service expansion. - Final approval of the theatre floor plan will be secured to support operational readiness and implementation planning. - A dedicated workforce plan is being developed alongside the mobilisation programme to ensure appropriate staffing arrangements are in place for the expanded service. - Mitigating actions will continue to be explored in relation to emerging staffing gaps within the surgery theatre team, recognising the potential impact on planned implementation timelines. - Progress towards opening the fourth theatre will continue to be monitored, with the anticipated go-live date currently expected in early November 2026	- Weekly multidisciplinary oversight provides assurance that theatre capacity, scheduling challenges and operational risks are reviewed and managed proactively. - Capacity and demand analysis is being undertaken to inform future planning and ensure theatre resources are utilised effectively. - The planned opening of a fourth theatre within the Sharoe Green Unit provides assurance that a longer-term solution is being implemented to improve capacity, resilience and operational flow. - Progress of the OG4 mobilisation programme, workforce planning and implementation milestones is monitored through established governance arrangements to ensure risks, dependencies and readiness requirements are identified and managed appropriately

Dashboard 5 - Graphs



OBSTETRICS AND GYNAECOLOGY CULTURAL IMPROVEMENT ACTION PLAN

Organisation:	Lancashire Teaching Hospitals NHS Trust
Lead Officer:	Emma Ashton
Position:	Divisional Midwifery and Nursing Director

Version	Date
1.0	October 2025
2.0	April 2026
3.0	September 2026

Status Key	
	Not yet commenced
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status			
						1	2	3	4
CULTURE CONVERSATIONS AND FEEDBACK FROM THE REVIEW									
1	Creating awareness of the culture review findings and generating commitment for action	- Feedback sessions held with senior stakeholders, seeking support and agreement around wider feedback and involvement approach. - Dedicated profession specific feedback sessions and action generation.	Louisa Graham and DMT	31.04.2026	As of end April 2026 – 13 feedback sessions have been delivered, to 1 x medical team, 1 x matrons, 1 x Band 7 midwives, 3 x delivery suite coordinators and 2 x admin and clerical team, 1 x Band 6 Midwives, 1 x Band 5 Midwives, 1 x Gynae leadership team, 1 x Gynae nurses, 1 x Midwifery Support Workers. Levels of attendance has been variable, however we have had representation for all groups				
2	Co-creating the culture and vision for Obstetrics and Gynaecology	- Hold regular Culture meetings involving all grades of senior staff to discuss progress against the action plan, assess levels of progress and commitment to bringing about cultural change. - Hold a visioning workshop for the leadership team to come together to design the future service vision, the actions they plan to take to improve multidisciplinary team working, culture and morale.	Louisa Graham and Emma Ashton	31/12/2026	Strong progress has been made for the midwifery and nursing workforce, with dedicated sessions held for Matrons and Band 7 Unit Managers. Sessions for this group of staff have now been scheduled every 6 weeks until Dec 2026. Less progress has been made with the medical team due to				

					leadership gaps at present. Team sessions to be scheduled with plans to move to MDT sessions once profession specific culture work has commenced.	
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Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
ROLE CLARITY & ROLE REVIEW						
1	To create rotational roles which provide a sense of team, job satisfaction and skill development whilst delivering a high-quality service	- To review the length of rotation into areas of Maternity to enable confidence and competence to be obtained. - To scope if rotational midwives can move areas as a cohort to create a sense of team. - To scope if rotational midwives can have a consistent line manager to provide consistency, get to know the individual, provide a meaningful appraisal, health and wellbeing support etc whilst liaising with the Unit lead for the area the rotational midwife is currently working. - To have dedicated rotational midwifery team meetings to ensure colleagues feel part of wider team and are updated on all services they have rotations within.	Emma Ashton	30/06/2026	Organisational change processes are underway	
2	To create a flexible and competent workforce who is able to work confidently across breadth of Maternity services	- To determine how skills will be maintained when in a Core Midwifery Role, to enable a greater proportion of the midwifery workforce to be flexible and support areas where staffing levels are a risk. - To determine how many rotational shifts Core Midwives may need to undertake on an annual basis to keep skills up whilst supporting the wider service.	Emma Ashton	31/04/2027	Work to reconfigure the workforce to support flexible working using the breadth of midwifery skills is ongoing. Progress aligned to the wider service changes.	
3	To review the responsibilities and accountabilities	To hold a team session with Matrons, And Band 7 leaders to identify roles, responsibilities, accountabilities and expectations to ensure there is role clarity.	Emma Ashton and	30/09/2026	In progress, initial RACI matrix has been completed with Matrons. Further actions include	

	of Maternity and Nursing Leadership roles	- To cascade and consult on draft RACI matrix. - To share the focus of leadership roles with wider midwifery and nursing workforce. - To clarify core objectives and impact measures for specialist roles, making this clear to wider Maternity Unit. - To determine how skills will be maintained when in a Specialist Midwifery Role, to enable a greater proportion of the midwifery workforce to be flexible and support areas where staffing levels are a risk.	Louisa Graham		consultation with wider leadership groups.	
4	To scope and review the Matron of the Day model and creating the role of the Unit Coordinator	- Review the purpose and focus of the Matron of the Day model and share responsibilities across the unit. - Scope and consult with Band 7 colleagues in Maternity about the potential of introducing the Unit Coordinator role - Review the role of the Delivery Suite coordinator when the Band 7-unit Coordinator role and rota is established - Develop standard operating procedures for the Matron of the Day, Unit Coordinator and Delivery Suite coordinator roles.	Marie Ryan	30/06/2026	Meeting held with key stakeholders to agree a plan for operationalisation of the Unit coordinator. Standard operating procedure developed in draft. Out for review. Planned go live date June 2026. Unit coordinator model has now been embedded and is working well	
5	To review the ways of working and role clarity within the administration teams	Hold a team session to review role boundaries, decision making, how to escalate issues and role of managers. The purpose of this session to reset on ways of working, distribution of workload, understanding what different roles do and how colleagues can provide cover.	Becky Cullen	30/09/2026	Session design has been scoped between OD and Ops Management Team. Dates delayed due to gaps in administration team this has not been able to progress until a substantive role recruited too.	
6	Create empowered teams with clear	Establish the roles and responsibilities of Band 6 midwives with regards to leadership and management when in charge of the ward or area.	Emma Ashton and	31/12/2026	This action has not yet commenced due to work around roles and	

	boundaries and role expectations	• Determine if a proportion of the Band 6 midwives would benefit from leadership and management development training if their role permits. • Review management processes and systems in ward and clinical areas to ensure staff are aware of what to do, who to escalate issues too and ensure Band 7's have the dedicated management time to complete people management elements of their roles.	Louisa Graham		responsibilities for Matrons and Band 7 managers needing to be concluded first.	
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Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3
WAYS OF WORKING						
2	To ensure colleagues where reasonably possible are able to take breaks during shifts across Maternity and Gynaecology	- To develop standardised process in which breaks can be allocated and taken across the Maternity Unit. - To develop communication plan which explains ways in which breaks will be allocated and the importance of taking breaks for rest and recovery.	Matrons	30/09/2026	Discussions held at both Matrons and Band 7 Managers Cultural Improvement Sessions. Work commenced with health and wellbeing teams to agree approach	
3	To review medical on call staffing for Maternity	- To scope and determine if there could be a two-tier Registrar roster to better support weekends and nights. - To scope and review medical on call process and determine if this could move to being Resident On Call, to provide greater support to clinical teams.	Operational Team	~~30/06/2026~~ 31/12/2026	Recruitment to the 2-tier rota is ongoing and 1 post remains unfilled. Once all posts in place on call arrangements to be revisited. This work aligns to wider recruitment to consultant workforce.	
5	Provision of rest and break facilities for the Gynaecology Ward	- To determine if there is space on or near the Ward which could be converted to provide break facilities for staff in Gynaecology. - Through the rest and recreation group and Staff Benefit Fund, determine if charitable funding could be used to support the creation of facilities.	Emma Ashton and David Styles	~~31/07/2026~~ 31/03/2027	Initial discussions have taken place at both Matrons and Band 7 Session, no suitable space can be found within Gynae Ward areas. Consideration now being given about space within the wider Sharoe Green Unit.	
6	Efficient, effective theatres	Provide culture feedback to Sharoe Green Theatres Team and Anaesthetists, understand their perspectives and develop localised culture improvement plan specifically around behaviours, ethos and attitudes.	Sharon Waite and Louisa Graham	30/09/2026	Meeting to be arranged with Matron and CD for Anaesthetics	

		- Review the working practices in the theatre team with regards to numbers of breaks and potentially where productivity could be enhanced. - For the medical team to engage in conversations with Anaesthetic team around supporting ward rounds and review of patients.				
7	Smooth running Gynae Assessment Unit service	- Review flow across the GAU in terms of how space is effectively utilised. - Review the use of the white board, to refresh the information on a regular basis to ensure it is current and clear.	David Styles Johanna Moshino	30/09/2026	Email to DMND to arrange meeting to agree SMART actions.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status			
						1	2	3	4
BEHAVIOURAL STANDARDS, PROFESSIONALISM AND CIVILITY									
1	To raise behavioural standards and professional ways of working	- To develop a set of practical, non-negotiable principles or standards/best version of us etc to define what respect, civility, kindness and professionalism looks like, ensuring these are embedded across Obstetrics and Gynaecology e.g. through in induction, feedback, meetings. - Run a series of workshops to launch the principles, standards and behaviours in sessions called ‘How We Behave Matters’, so all colleagues understand their role in creating a positive organisational culture such as role modelling, addressing unacceptable behaviours and celebrating positive approached. - To deliver in situ human factors training to illustrate the impact non-technical skills such as incivility, low psychological safety, unprofessionalism, relationship breakdowns can have on patient safety.	Emma Ashton and Louisa Graham	30/09/2026	Initial set of non-negotiable behaviours have been drafted in partnership with Matrons and Band 7 managers in Maternity and Gynae. These will be reviewed in subsequent sessions. Wider actions have not yet been progressed, also other professional groups have not been engaged in the design of the non-negotiable behaviours, this will need to form part of future actions				
2	To reset behaviours, values and communication approach within the Admin Teams	As part of programme of team development, hold a workshop which helps the team to refocus the expected values, behaviours and ways of communicating. To include civility and how to constructively call out behaviours not in line with what has been agreed. Understand how to give, receive feedback reflect and act.	Becky Cullen	September 2026	Session has been scoped with OD. Dates not yet in place due to resourcing challenges in the administration team.				
3	To create a trauma informed ethos -	To surface any further hurt, harm feelings of injustice around past events, to discuss feelings perceptions and what colleagues need to move forward.	Louisa Graham	Dec 2026	Actions to be agreed Not yet commenced.				

	supporting colleagues to let go of the past, to prevent past issues continuing to impact behaviours, colleague experience today and in the future	Deliver trauma informed leadership and team development training sessions, to help build healthy practices when dealing with challenging situations.				
4	To create a zero-tolerance culture	- For all colleagues to participate in a zero-tolerance workshop, understanding what behaviours are unacceptable, how to be an effective bystander, how to call it out in the moment, de-escalation, reporting incivility and negative behaviours. - For all leaders to participate in Zero Tolerance masterclass to understand their role in creating the culture and conditions around tackling any form of bullying, harassment, abuse or discrimination.	Kate Holt	31/12/2026	Not yet commenced	
5	Create freedom to speak up culture and visible responses to concerns raised	- To hold Freedom to Speak Up sessions in the team, to raise awareness of mechanisms to speak up about concerns. - To recruit Maternity FTSU Champions. - For the FTSU Guardian to hold regular 'drop in sessions' across site for Maternity to increase visibility and support around FTSU - To connect the Professional Midwifery Advocates with FTSU guardian to deliver joint supportive presentations to share how colleagues can raise concerns.	Chris Cain	30/09/2026	Drop-in sessions have been held in Maternity on 8 th April 2026. This work will be rolled out across specialty	
6	To create a culture of inclusion	To deliver a range of EDI training and awareness session to help colleagues understand their role in challenging discrimination and creating an inclusive workplace. Sessions could include Banter	Mandy Davis	31/03/ 2027	Work plan to be agreed	

		– When it is not a laughing matter, Cultural Competence, microaggressions etc. - To scope how the Maternity Unit and Gynaecology Ward could support inclusion campaigns, such as promoting on notice boards when is it Disability History Month, LGBTQ+ month, Black History Month, Eid etc.				
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Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status			
						1	2	3	4
MANAGEMENT ACTIONS AND APPROACH									
8	To have strong, effective leaders and managers	- To review if all team leaders (Ops Managers and Matrons / Band 7 Managers) and above have attended Core People Management Skills. Supporting those colleagues who havent attended to be able to access this development. - To review which Consultants have attended Consultant Leadership Development and Consultant Stretch. Supporting those colleagues who havent attended to be able to access this development. - To prioritise attendance of Managers on Matrons Programme, Ward and Unit Managers Programme and Senior Leadership Development (Ops managers) - Readvertise and direct managers to Monthly Managers Updates and Managers Hub for resources.	Paul Tremain	Sept 2026	Matrons have been allocated to programmes, which are due to commence from June 2026. Review of who has previously attended programmes to be undertaken.				
10	Provide supportive supervision	To scope how regular 1-1 discussions could take place to enable all colleagues in the team to meet with a more senior colleague on a regular (to be	Paul Tremain and	31/03/2027	Action to be agreed				

	and meaningful appraisal	determined) to give and receive feedback, talk about their development, refocus their objectives, discuss their wellbeing and job satisfaction. • To implement the 1-1 process and paperwork available. • For all appraisers to attend appraisal and objective setting masterclass. • For an in-depth quality audit to be undertaken by OD to review the quality and consistency of completed appraisal paperwork, then subsequently development actions to strengthen appraisal quality.	Samantha Kenny			
11	Provide supportive debrief following incidents aligned to the restorative just culture approach described in the NHS Being Fair guidance	• Equip leaders with the skills to support staff involved in incidents. • To understand how to apply the 'Being Fair' just culture approach to incident investigation and review. • Train leaders in debrief methodologies, guided facilitation conversations and wellbeing discussions.	TRIM practitioners	31/10/2026	Work with TRIM practitioners and OD to agree training plan	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
COLLEAGUE EXPERIENCE						
1	For colleagues to feel valued and recognised	- Scope local reward and recognition schemes to understand what colleagues would appreciate which could be implemented across Maternity Unit and Gynaecology. - To share patient compliments received on a monthly basis, through local communications and notice boards. - To participate in the Thank You tool and OD recognition events.	OD Team	30/09/2026	Plan for communicating reward and recognition events to be agreed between specialty and OD.	
3	To improve colleague experience and levels of staff satisfaction	- To undertake a detailed review of the staff satisfaction results, comparing 2026 data, against performance in 2025. - Share results with all colleagues to demonstrate their feedback has been listened to and want to take action to bring about improvements (could be done in partnership with suggestions in this plan). - To hold a series of focus groups/big conversations with all colleagues to understand what actions would further support improvement beyond actions contained in this report.	Louisa Graham	March 2027	Not yet commenced as next staff survey for 2025 will need to be completed first, results only expected in January 2027.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
CROSS TEAM & CROSS PROFESSIONAL WORKING						
1	Strong, respectful and dynamic multidisciplinary teams	- To run a series of team development sessions for the multi-disciplinary leadership team (medical and inclusive of Band 7s) to build understanding of one another's leadership approach and values. - The sessions also need to include an increased awareness of the pressures and priorities for each area to create greater understanding of the challenges and focus for each team. - To create a shared ethos of what it means to work in this team that all leaders can buy into and role model. - To have a collective discussion across Delivery Suite Coordinator roles and Consultant team around skill sets of junior doctors, to agree how best to support resident doctors/trainees to develop and build their skill set supportively. Consideration as to how have professional skills hand over discussions, help resident doctors to understand how midwives can help etc. - To undertake an MDT TED and feedback session to determine if improvements have been made.	Louisa Graham, Emma Ashton, Richa Gupta	Nov 2026	Not yet commenced due to completing profession specific development sessions first.	
2	To have effective escalation processes	- To revisit as a MDT what effective escalation is, the response, behaviours and support colleagues will show one another. - To develop shared expectations around on call cover from consultants when the Unit is closed, or they are leaving the Unit	Louisa Graham, Emma Ashton, Richa Gupta	Nov 2026	Not yet commenced due to completing profession specific development sessions first.	
3	Have smooth transfer of patients	To bring together representatives from all teams which make up the Maternity Unit to discuss and	Louisa Graham, Emma	Nov 2026	Not yet commenced due to completing profession	

		agree the shared approach to how patients will be transferred. This to include the welcome, handover, questioning approach etc.	Ashton, Richa Gupta		specific development sessions first.	
4	Shared decision making which is respectful of professional views and ensures patient safety	- For members of the midwifery leadership team and consultants to discuss decision making boundaries, what professional respect looks like around care planning decisions. - To have a facilitated discussion to explore the reasons why shared decision making and professional respect is an issue and identify the shared actions which would support improvements. - Agree the process and response when colleagues raise concerns or suggest different approaches to ensure patient safety is always maintained.	Louisa Graham, Emma Ashton, Richa Gupta	Nov 2026	Not yet commenced due to completing profession specific development sessions first.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status			
						1	2	3	4
TEAM EFFECTIVENESS & ENGAGEMENT									
1	Increasing team effectiveness and cohesiveness in the Medical Team	- To run a series of team development sessions for the medical team. - The sessions also need to include an increased understanding of preferences and personality types, to raise awareness of individual and collective motives, values and styles of communication. - Also session need to be held to understand the skills, experience, service aspirations and challenges to have greater appreciation of how each other can support the wider team and greater awareness of pressures being experienced. - Session to consider how the team create a shared ethos / standards / values of what is means to work in this team that all colleagues can buy into and role model. - Session to develop shared expectations around roles, responsibilities and expected ways of working e.g. around escalation, responsiveness etc.	Richa Gupta and Clinical Director	Sept 2026	Actions not yet begun due to gaps in leadership structure				
2	To be a high performing, efficient and effective medical team	- Agree the areas of performance to be improved over the next 12 months. - To engage colleagues in developing a shared plan which will support improvement, with clear timelines, accountability and responsibilities defined. - To agreement how improvement will be measured.	Richa Gupta and Clinical Director	Sept 2026	Actions not yet begun due to gaps in leadership structure				
3	Coaching and mentoring of new medical colleagues	- To establish a coaching network within the Obstetrics and Gynaecology Team. - For ‘new’ consultants to be offer coaching or mentorship via the Coaching Hub (if internal mentorship not available).	Richa Gupta and Clinical Director with	March 2027	Actions not yet begun due to gaps in leadership structure				

		To train consultant colleagues in coaching skills.	sessions provided by OD			
4	To create a feedback culture in the medical team	- Introduce Hot Debriefs within the team and wider department (MDT) as a way to provide real time feedback in a safe and open environment. - At end of shift / day, build in time for feedback for resident doctors to support them to understand strengths and areas for development, seek clarity and give feedback on their day.	Richa Gupta and Clinical Director	March 2027	Actions not yet begun due to gaps in leadership structure	
5	Increasing Matron team effectiveness, creating a shared vision and direction to deliver cultural improvements	To hold a development day with Matron team to agree role focus, levels of accountability, their role in bringing about cultural improvement and to agree the actions which will be taken forward.	Emma Ashton and Louisa Graham	17 th March 2026	Session scheduled and session plan scoped. Draft RACI matrix populated for Matrons and Band 7 roles. Initial projects allocated to wider team.	
6	Increasing Ward Managers and Delivery Suite Coordinator management team effectiveness, creating a shared vision and direction to deliver cultural improvements	To hold a development day with Band 7 leaders and Matrons to focus the role of band 7 leaders, gather their reflections on their role in providing cultural improvement, to address any past concerns to support the team to move forward, to understand what makes a perfect shift, to increase understanding of each others roles and challenges to develop a shared action plan which creates greater cohesion across teams	Emma Ashton and Louisa Graham	16 th April 2026	Session scheduled and session plan scoped. Session focussed predominantly on the non-negotiable behaviours, providing the opportunity for leaders to understand one another's challenges. Further sessions have been scheduled every 6 weeks till December for Band 8a and Band 7 Midwifery and Gynae Leaders to focus on ongoing Cultural Improvement.	
7	Supporting team cohesion and effectiveness	Hold a series of team sessions with core midwives, to engage them in setting out their vision for the delivery suite, the actions which need to be taken to achieve goals. To understand what a good shift	Delivery Suite Coordinators	November 2026	Action not yet begun, this will need to be sequenced once the Midwifery and Gynaecology Leadership	

	of the Delivery Suite Core Team	looks like and what factors need to consistently be in place to support shifts to run well. To engage the core team in identifying the actions to support cultural improvement such as behavioural change, inclusions, local reward and recognition, support around difficult incidents.			Cultural Improvement Sessions have further progressed.	
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Maternity workforce action plan

The NHS long term workforce plan (2023) has developed three clear priority areas for NHS workforce for the future:

- **Train – grow the workforce:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
- **Retain – embed the right culture and improve retention:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
- **Reform – working and training differently:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

The NHS maternity and neonatal delivery plan (2023) also focuses on NHS workforce through the theme of growing, retaining, and supporting our workforce. Objective 4 and objective 5 focuses on:

- **Grow our workforce – supporting workforce capacity to grow to meet the needs of service users**
- **Value and retain our workforce – support staff to feel valued at all stages of their career and have equality of opportunity.**

Standard	Objective	Overview	Lead	Detail	Date for completion	Progress	Current Status
							1 2 3 4
1	Train	Scope the availability to support student midwives in the clinical setting, with a focus on providing a good and supportive experience	Lead for student midwives – Sarah Dixon Matron for Safety and Quality – Neesha Ridley	Review the available areas suitable for training student midwives in line with the NMC standards	31 December 2025	01.09.2025 Action ongoing meeting with Education team arranged UPDATE 16.9.26 – Action plan created and shared with Trust education team and local HEI providers. Face-to-face meeting arranged and completed onsite on 22.4.26 with HEI education providers to collaborate and share action plan updates. Action complete	
				Review the number of practice supervisors and practice assessors in the maternity workforce at LTH	31 December 2025	01.09.2025 Review practice supervisors and confirm enough. Agree funding as required for further mentorship. UPDATE 16.9.26 Currently there are 140 Practice Assessors. Practice Assessor training is completed by all NQM at the end of their preceptorship to maintain numbers needed. Action complete.	
		Scope the plans for recruitment for diversity in the workplace. Review and understand the options and	Matron for Safety and Quality – Neesha Ridley	Discuss with the educational providers to seek clarity on diversity and equity workforce plans during recruitment of student midwives.	30 December 2025	01.09.2025 Awaiting update from regional team meeting UPDATE 02.03.26 – LMNS Workforce and Education meeting complete on 03 December 2025, and Midwifery	

		data from education providers.				vacancy group led by NHSE attended on 14 November 2025 by S&Q Matron and feedback shared. Action complete
		Support offered to student midwives to prepare for qualification and employment collaboration with local education providers, the LMNS and NHS England regional team	Matron for Safety and Quality – Neesha Ridley	Create discussion at next LMNS workforce meeting – discussion with Lead midwives for education (LME) and education providers. Request LMNS review at next Regional workforce meeting.	30 December 2025	01.09.2025 Awaiting update from regional team meeting UPDATE 02.03.26 – LMNS Workforce and Education meeting complete on 03 December 2025, and Midwifery vacancy group led by NHSE attended on 14 November 2025 by S&Q Matron and feedback shared. Action complete
		Feedback from student midwives.	Lead for student midwives – Sarah Dixon Matron for Safety and Quality – Neesha Ridley	Review the feedback from the three sources of data and develop an action plan to address areas where negative feedback has affected the student midwifery experience.	30 December 2025	01.09.2025 Data currently being analysed and triangulated. Development of action plan in progress. UPDATE 16.9.26 – Action plan created and shared with Trust education team and local HEI providers. Face-to-face meeting arranged and completed onsite on 22.4.26 with HEI education providers to collaborate and share action plan updates. Action complete
				Share feedback by meeting with Chief Nursing Officer to share feedback on learner experience	30 September 2025	01.07.25 Face to Face Meeting with CNO arranged July 2025. Outcomes shared via safety Champions (bi-monthly meeting). Action complete
		Catch-up sessions for student midwives	Lead for student midwives – Sarah Dixon	Host regular in-house catch-up sessions for student midwives, with an open agenda to support their clinical placement experience and to address any areas of development they need support with.	31 December 2025	01.09.2025 Regular catch ups in place on cycle of business led by lead for student midwives. Action complete

2	Retain	Preceptorship document	Lead for NQM midwives – Sarah Dixon	Review the NQM preceptorship pack, to check that it is aligned with the LMNS, local and national clinical need and evidence-based practice.	30 December 2025	01.09.2025 Document reviewed annually on 01.09.2025 and updated in line with LMNS working group. Action complete
		Preceptorship clinical rotation plan	Matron for Midwifery led services – Laura Thorpe	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan in preparation of the new midwifery workforce at LTH. Consider the key areas of practice to support new midwives and also the need of the clinical service.	30 October 2025	01.09.2025 Review of preceptorship programme ongoing in line with service reconfiguration. Document reviewed on 01.09.2025 and updated in line with LMNS working group. Action complete
		Retention meeting	Lead for NQM midwives – Sarah Dixon	Develop a retention, regular face-to-face session for new midwives to LTH, with an open agenda to support their development and their experience as midwives at LTH.	30 December 2025	01.09.2025 Regular coffee catch up's, 121's and surveys in place delivered by preceptorship lead. Retention and preceptorship action plans shared with LMNS during face to face meeting November 2025. Action complete
		Mentor support plan	Matron for Midwifery led services – Laura Thorpe Lead for NQM midwives – Sarah Dixon	Develop a mentor support plan, to support all new midwives at LTH for the first 12 months. A buddy mentor should be assigned to all new midwives at LTH to support them alongside their line manager.	30 December 2025	01.09.2025 Matron and Preceptorship lead midwife to arrange planning meeting. 16.9.26 – Update NQM are supernumerary for the first three months. Planned buddy system ready for implementation. Action complete.
		New starter support	Lead for NQM midwives – Sarah Dixon	Include details of new starter forums, freedom to speak up, wellbeing support and inclusion	30 December 2025	01.09.2025 Discussed during induction for new starters and embedded in each induction session when new

				forums in preceptorship packs. Share the details of these LTH trust forums with buddy mentors, to share with new midwives.		recruits commence in post. Action complete.
		Survey about development options	Lead midwife for education – Britt Ogdin	Develop and send a survey to all midwives, asking what the key areas of development are of interest to them. Share the results with team leaders to support development in appraisal feedback.	30 January 2025	01.09.2025 Survey to be shared with all midwives seeking feedback on areas of development 16.9.26 – Survey has been circulated to all midwives to offer CPD support in Jan 26. This offer is due to be repeated in October.
		B7 leadership development pack	Matron for Safety and Quality – Neesha Ridley	Develop a B7 leadership development pack aligned to NHS England's Labour ward co-ordinator framework , to support the learning, support and development. Document to be tested before full roll out.	30 October 2025	01.09.2025 Documentation developed and test of change in progress. B7 leadership development pack presented and shared with LMNS and NHSE NW regional maternity team on 03 December 2025 in the Education and Workforce meeting. Action complete
		CPD funding	Lead midwife for education – Britt Ogdin	Share awareness of the CPD funding to team leaders and ward managers, to share with midwives and maternity staff	30 October 2025	01.09.2025 Email to be sent to all staff in line with CPD funding availability. Applications reviewed by Education lead, S&Q matron and DDMND. Action complete
		Celebrating success	Ward managers – HM, LD, HA, LM and SH.	Share with ward managers and team leaders, encouraging them to use resources Celebrate Success on the intranet, tools to help enhance feeling valued and recognised.	30 October 2025	01.09.2025 Managers to utilise shared resources developed by OD team. Action complete

3	Reform	Await the outcome of the culture review and associated action plan.	Organisational Development Team and QUAD	Action to be aligned to the wider culture improvement plan. To discuss actions at the next perinatal meeting and await overarching improvement plan which is expected by the end of September.	30 December 2025 31 March 2027	01.09.2025 Awaiting analysis and final report from ongoing culture workstream. 16.9.26 – Work is ongoing to implement the recommendations from the culture review.
		Review the service needs and staffing	Emma Ashton – Divisional Midwifery and Nursing Director	Review the staffing models in each of the clinical areas – complex care, midwifery led care and continuity of carer. Review the service needs to support women, service users to receive excellent care and review staffing numbers needed to support the needs of the service.	30 December 2025	01.09 2025 Service reconfiguration ongoing 16.9.26 – Following consultation meetings with clinical staff in all areas a draft plan for realignment of staffing model to meet the needs of the service has been drafted. Action complete.
				Undertake Birthrate plus assessment to ascertain recommended establishment	30 December 2025	14.10.25. Ongoing – awaiting report 16.9.26 – BR+ assessment complete and action plan in place following report. Action complete
		Annual leave and study day delegation	Ward managers – HM, LD, HA, LM and SH.	Ward managers and team leaders to review annual leave and study day delegation to support the needs of the service and to support staff wellbeing.	30 December 2025	01.09.2025. Monthly roster reviews set up and ongoing to balance study day allocations. Education lead has completed a trajectory for annual training compliance aligned to CNST Y8. Action complete.
		Recruitment to the maternity service	Matron for Midwifery led services and complex care – Laura Thorpe	Advertise vacancies for band 5 and band 6 midwives, to support recruitment to vacancies in maternity staffing gaps at LTH.	30 September 2025	01.09.2025- Vacancy of 18.45 WTE recruited to and further recruitment in progress for fill of outstanding various hours. Action complete

			and Marie Ryan	Share details of the advertised posts with local educational providers to share with students.	30 September 2025	01.09.2025- Vacancy of 18.45 WTE recruited to and shared with local HEI at point of advert. Action complete
				Monitor vacancies using spreadsheet trajectory	31 March 2026	01.09.2025 Monthly review and oversight ongoing 16.9.26 – Review meeting held with Matrons and Divisional Senior Finance Business partner on 16.09.26 and agreed that further 5.0 WTE for Band 5/6 Midwives to be added to TRAC for recruitment. Action complete.
		Utilise national over offer	Deputy Divisional Midwifery and Nursing Director - JL	Use national over offer to recruit to turnover to ensure sustainable workforce.	31 March 2026	01.09.2025 National over offer in place to recruit to turn over 16.9.26 – 13.4 WTE Band 5/6 Midwives appointed (includes utilisation of 6.4 WTE over offer) following August interviews. Start dates from October onwards. 2 WTE remain to account for maternity leave returns. Action complete.
		Oversight of data	Deputy Divisional Midwifery Director – Jo Lambert	Monitor safety data on a monthly basis, including red flag data, BR + acuity, safety huddles, PALS concerns, complaints and service user feedback.	Monthly – data collated and feedback through the Patient experience feedback report (Quarterly)	01.09.2025 Perinatal Quality Surveillance Dashboard used to monitor data. Guideline in place and published. UPDATE 17.9.26 Q1 report patient experience report shared at Maternity S&Q meeting on 17.9.2026. Red flag data shared monthly through the governance monthly report at Maternity S&Q. Action complete

		Cascading of data	Matron for Safety and Quality – Neesha Ridley	Gathering and sharing of patient experience report data through the Quarterly report 2025, shared via the patient experience trust group	Patient experience feedback report (Quarterly – presented at Trust Patient experience group)	01.09.2025 Report shared via maternity safety and Quality Committee. UPDATE 17.9.26 Q1 report shared at Maternity S&Q meeting on 17.9.2026. Action complete

NEONATAL WORKFORCE ACTION PLAN

Organisation:	Lancashire Teaching Hospitals NHS Trust
Lead Officer:	Joanne Connolly
Position:	Divisional Nursing Director (Neonates)

Version	Date
1.0	22 September 2026
2.0	
3.0	

Status Key	
	Not yet commenced
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status			
						1	2	3	4
1	Neonatal Nursing not meeting BAPM standards (2.0WTE cot side nurses short)	Use of temporary staffing to ensure safe staffing	DND	31/03/2027	Vacant shifts put out to bank to provide appropriate cover				
		Biannual safe staffing review by the Chief Nursing Officer	DND	31/10/2026	Date in diary for the biannual review in October 2026				
		Consider development of business case if required to support neonatal nurse staffing	DND and DD	31/12/2026	Await outcome of biannual review				
2	Specialist nursing capacity impacting on ability to fulfil all workstreams	Review Specialist Nursing capacity as part of the Biannual safe staffing reviews by the Chief Nursing Officer	DND	31/10/2026	Date in diary for the biannual review in October 2026				
		Consider development of business case if required to support neonatal nurse staffing	DND and DD	31/12/2026	Await outcome of biannual review				

3	Allied Health professional and Specialist support	Progress business case for psychologist in line with national recommendations	DD	31/03/2027	Business case has been developed and is going through Trust process	
4	Transitional care nursing model requires substantive staffing 27/7 (5.51WTE)	Review transitional care nursing model as part of the biannual safe staffing reviews by the Chief Nursing Officer	DND	31/10/2026	Date in diary for the biannual review in October 2026	
		Consider development of business case if required to support neonatal nurse staffing	DND and DD	31/12/2026	Await outcome of biannual review	
5	Neonatal medical staffing does not currently meet BAPM compliance	Complete comprehensive review of the neonatal medical workforce including job plans, service requirements and programmed activities	DMD and CD	31/12/2026	Review of workforce has commenced	
		Use of temporary staff to ensure safe staffing during this review	CD	31/03/2027	Locum cover utilised to support safe staffing where gaps are identified	
		Consider development of business case if required to support neonatal medical staffing	CD and DMD	31/03/2027	Await outcome of neonatal medical workforce review	

11.1B BI-ANNUAL ADULT & CHILDREN SAFE STAFFING REVIEW

● Decision Item

REFERENCES

Only PDFs are attached



11.1b Bi-Annual Adult & Children Safe Staffing Review Ancillary Board Pt I October 2026.pdf

Meeting of the	Board of Directors	01 October 2026
Title of Report	Bi-annual Nursing and Midwifery Workforce Review	
Report Author	Catherine Gregory - Deputy Chief Nursing Officer, Nicola Ross – Head of Safe Staffing	
Lead Executive Director	Sarah Morrison Chief Nursing Officer	
Recommendation/ Actions required	The Board of Directors is asked to: approve the bi-annual staffing review to the Board, confirm it is satisfied of the assurances within the report.	
	Decision ☒	Assurance ☐
		Information ☐

1. Introduction

This report provides a six-month update on safe staffing across the Trust in line with national guidance. The review has been conducted as a desk top review by the Chief Nursing Officer (CNO). This has included the Deputy CNO, Matron for Patient Safety and Safe Staffing and involving each Divisional Nurse Director from the Clinical Divisions. The review triangulates workforce data with patient safety, experience and quality indicators to ensure staffing establishments remain safe and appropriate.

This report provides a six-month review of safe staffing across the Trust, fulfilling national requirements including:

- NHS Improvement: Developing Workforce Safeguards (2018)
- National Quality Board guidance
- NICE Safe Staffing Guidance

It triangulates workforce metrics with patient safety, experience and clinical effectiveness data to ensure safe staffing establishments remain appropriate.

2. Scope

The review covers five divisions:

1. Medicine
2. Surgery
3. Women's
4. Children's
5. Diagnostic & Clinical Support

Including inpatient wards, assessment areas, maternity, neonates and paediatrics.

3. Methodology (Alignment to National Guidance)

The review has been undertaken in line with NHS Improvement workforce safeguards, National Quality Board guidance and NICE safe staffing principles.

A triangulated approach has been used, drawing on acuity and dependency tools (Safer Nursing Care Tool and Birthrate Plus), workforce data (vacancy, sickness and fill rates), patient safety and experience indicators, and professional judgement validated by Divisional Nursing and Midwifery leaders. This ensures that staffing is assessed against both evidence-based measures and the operational context in which care is delivered.

This review represents the first cycle incorporating the Safe Staffing Quality Assurance Dashboard, providing enhanced triangulation of workforce, quality, safety and patient experience metrics and strengthening organisational oversight of safe staffing risks.

4. Outcome of the Review

The review concludes that staffing establishments remain safe and appropriate across all divisions. Assessment of staffing requirements incorporated validated workforce planning tools, workforce metrics, quality indicators and professional judgement. Although differences between funded establishment and calculated workforce requirements were identified in some services, these did not correlate with deterioration in patient safety, patient experience or clinical outcomes. Appropriate mitigation and escalation arrangements were in place where required.

Across Medicine and Surgery, staffing is sufficient to meet patient need. Some variances in SNCT requirements are evident in high-acuity areas, assessment units and services experiencing operational reconfiguration, increased dependency and patient flow pressures. Whilst these factors have reduced workforce resilience in some areas, triangulation confirms safe care is being maintained through established mitigation and escalation processes.

In the Emergency Departments, SNCT variance is recognised and expected due to the limitations of the tool in reflecting prolonged length of stay, corridor care and boarding. Professional judgement, supported by operational data, confirms that safe care continues to be delivered, albeit within a highly pressurised environment.

Within Diagnostic and Clinical Support Services, Critical Care staffing was assessed as safe, supported by improving sickness absence trends, stable staffing performance and positive peer review findings. The principal risks identified relate to workforce sustainability, pharmacy provision, rehabilitation capacity and wider multidisciplinary team optimisation rather than immediate patient safety concerns.

In Children's services, SNCT and professional judgement confirm safe staffing. Variance is minimal; however, workforce sustainability risks have been identified, particularly within neonatal services due to sickness levels and specialist staffing requirements.

Within Women's services, staffing is considered safe when triangulated. Birthrate Plus and workforce data highlight ongoing gaps and pressure within the obstetric workforce, alongside leadership and cultural challenges. This division represents the highest risk, although no direct correlation with patient harm has been identified.

4.1. Cross-Cutting Themes

The review identified a number of recurring themes across divisions:

- Workforce sustainability and recruitment within specialist and support worker roles.

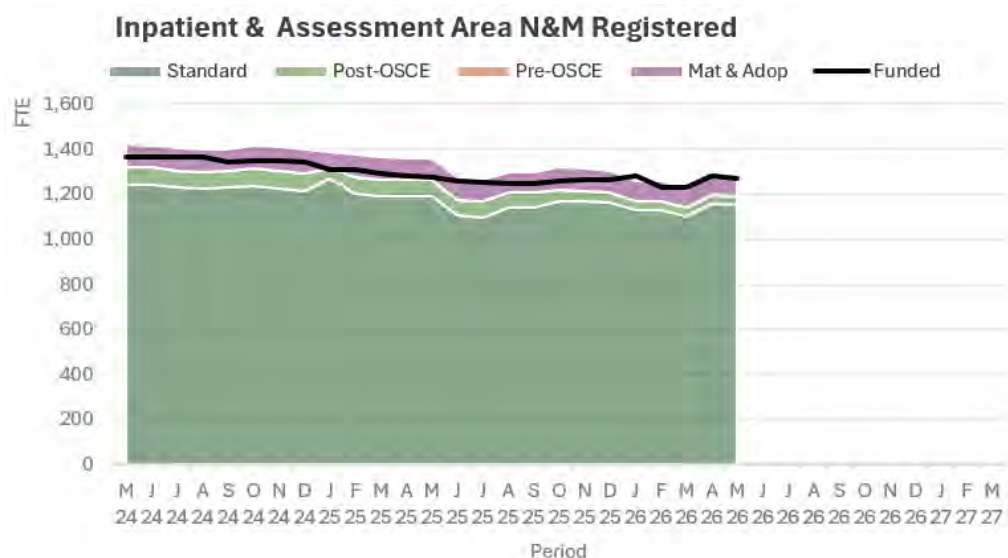
- Increasing patient acuity, dependency and enhanced care requirements.
- Ongoing patient flow pressures impacting operational resilience.
- Leadership capacity and succession planning.
- Training and education demand exceeding traditional workforce headroom assumptions.
- Pharmacy provision affecting medicines management and discharge processes.
- Cultural and staff experience challenges within specific services.
- Opportunities to improve digital workforce and quality monitoring capability.

These themes represent the principal workforce risks identified through the review and inform the divisional action plans developed following completion of the review.

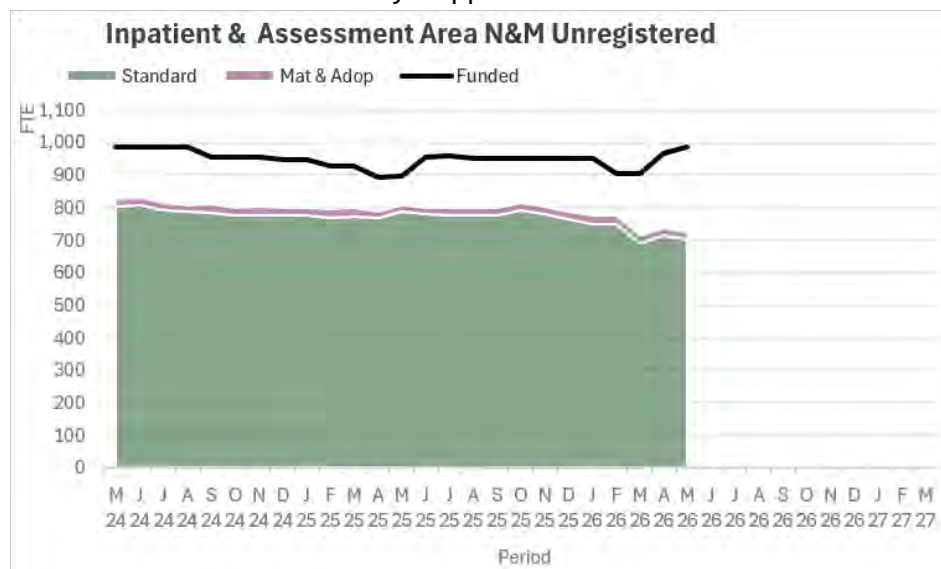
4.2. Vacancy Position

The registered nurse vacancy position continues to remain within a manageable risk profile when considered alongside recruitment pipelines, workforce deployment arrangements and patient safety outcomes. Whilst vacancies remain within a small number of specialist services, there is no evidence through triangulation of quality, safety and patient experience indicators that these are adversely affecting the delivery of safe care.

Graph 1 - Registered Nurse & Midwifery establishment versus staff in post



Graph 2 - Healthcare Assistant & Maternity Support Worker establishments versus staff in post



The workforce profile demonstrates a sustained improved position in the registered nurse position. Consistent seasonal variation is seen in the Midwifery position with a plan to over offer again by 10WTE this year to mitigate the expected backward given due to the movement around the region when newly qualified students qualify. In contrast, the Healthcare Support Worker and Maternity Support Worker workforce continues to experience a more significant establishment gap, reflecting the ongoing recruitment challenges identified through this review.

The most significant workforce challenge continues to be within the Healthcare Support Worker (HCSW) workforce, where vacancy levels remain elevated across inpatient services. This has increased reliance on temporary staffing and presents a residual risk where shifts cannot be fully filled. However, robust mitigating actions are in place and are subject to regular oversight through established workforce and safe staffing governance arrangements.

A coordinated recruitment and workforce development programme is being delivered through collaboration between Recruitment, Education and Safe Staffing teams, with a focus on both external recruitment and the development of internal career pathways. A structured Band 2 to Band 3 development programme commenced in April 2026 and will operate on a rolling basis to support workforce progression and establish a sustainable pipeline into Band 3 roles. In parallel, bank workers are being supported to transition into substantive posts to improve workforce stability and reduce reliance on temporary staffing.

As part of the review process, a test of change has been agreed within the Acute Medical Unit (AMU) workforce model. The review identified ongoing challenges in recruiting to Band 3 Healthcare Support Worker directly into posts, with limited success through recruitment activity. AMU is currently established predominantly with Band 3 Healthcare Support Worker roles; to improve recruitment opportunities and workforce resilience, a test of change will introduce 2 WTE Band 2 Healthcare Support Workers per shift. This will align the support workforce more closely with comparable assessment areas and enable appointment of staff currently awaiting allocation to vacant posts. The test of change will be managed within the existing workforce budget and will be subject to ongoing monitoring through established safe staffing governance arrangements. Outcomes will be formally evaluated as part of the annual staffing review cycle commencing in October 2026, including assessment of recruitment, fill rates, workforce stability and impact on service delivery.

The review found no direct evidence that current vacancy levels are resulting in a deterioration in patient safety, patient experience or quality outcomes albeit there is an increase noted in pressure ulcers and complaints and it is likely the lack of substantive staff will be a feature of this. The Trust continues to maintain safe staffing levels through robust escalation processes and daily staffing management arrangements. However, it is recognised that the optimum staffing model is one in which services are staffed predominantly by substantive employees working within established teams, enabling continuity of care, professional relationships and cohesive team functioning. Whilst current mitigations are effective in maintaining safety, ongoing vacancies and workforce pressures may impact team stability and resilience, reinforcing the importance of continued recruitment and retention efforts.

4.3. Roster and Fill Rates

Review of roster performance and staffing fill rates demonstrates that inpatient services have continued to maintain safe staffing levels throughout the reporting period through a combination of substantive staffing, flexible workforce deployment, daily staffing reviews and the appropriate use

of temporary staffing. Triangulation with quality, safety and workforce indicators identified no evidence that roster performance has adversely impacted patient safety outcomes across inpatient services.

Within Medicine and Surgery, roster performance continues to support safe care delivery despite sustained operational pressures associated with patient flow, high occupancy and increasing patient acuity. Assessment areas and high-turnover environments require frequent staffing adjustments to respond to fluctuating demand, however professional judgement and quality indicators confirm that staffing arrangements remain appropriate and responsive to patient need.

Within Women's Services, fill rates continue to be affected by workforce gaps within the obstetric and midwifery workforce, alongside higher sickness levels and the ongoing requirement to support service improvement activity. Whilst these pressures continue to present a workforce sustainability risk, triangulation with quality and safety indicators did not identify evidence of patient harm directly attributable to staffing levels. Workforce deployment, temporary staffing arrangements and enhanced oversight have been utilised to maintain safe staffing and support service resilience.

Children's Services identified some variability within roster and fill rate metrics during the review period; however, triangulation with Royal College of Nursing (RCN) defining staffing levels, professional judgement and quality indicators confirmed that staffing remained safe and responsive to patient need. Within Neonatal Services, workforce pressures were associated with sustained sickness absence and increasing demand arising from higher dependency patients and prolonged neonatal admissions, impacting workforce resilience rather than immediate safety.

Critical Care demonstrated improving workforce stability, reflected through reducing sickness absence and lower reliance on additional bank shifts. Whilst temporary staffing continues to be utilised to support elements of the support workforce model, the service has maintained safe staffing through effective workforce planning, flexible deployment and strong clinical leadership.

Overall, the review found that roster governance arrangements are well established and continue to mature through divisional oversight, workforce review processes and routine monitoring of staffing metrics. Staffing risks associated with fill rates are well understood and are being actively managed through recruitment initiatives, workforce development programmes and operational staffing processes.

5. Risks and Mitigation

The review identified risks primarily relating to workforce sustainability and service resilience rather than immediate patient safety. These include workforce capacity, patient dependency, patient flow pressures, pharmacy provision, leadership resilience and cultural challenges within specific services.

These risks are being actively managed through targeted recruitment and retention initiatives, workforce development programmes, establishment reviews, flexible workforce deployment, sickness reduction programmes and service-specific improvement plans. Trust-wide programmes to improve patient flow and discharge continue, while pharmacy provision has been escalated as a cross-cutting organisational risk. Women's Services continue to implement a structured cultural improvement programme supported by leadership development and organisational development resources.

Following completion of the review, divisional action plans have been developed to address the risks and themes identified within each service area. Actions include workforce recruitment and retention, roster efficiency, leadership resilience, workforce planning, training compliance, pharmacy provision and service-specific quality improvements. Progress against these actions will be monitored through divisional governance arrangements and the Trust's established safe staffing governance framework, providing ongoing assurance that identified risks are being actively managed and mitigated.

6. Assurance Statement

This review provides assurance that nursing and midwifery staffing establishments remain safe, effective and sustainable across Lancashire Teaching Hospitals NHS Foundation Trust. No evidence was identified through workforce, quality, safety, patient experience or professional judgement indicators to suggest that current staffing arrangements are resulting in widespread harm or deterioration in the quality of care. Risks identified relate primarily to workforce sustainability and service resilience and are subject to active management through established governance arrangements.

In line with NHS Improvement's Developing Workforce Safeguards (2018), the Chief Nursing Officer confirms that a comprehensive review of nursing, midwifery and support worker staffing has been undertaken using validated workforce planning tools, workforce metrics, quality indicators and professional judgement. Having considered the findings, current staffing establishments are assessed as safe, effective and sustainable and continue to support delivery of high-quality patient care.

7. Recommendations

The Board of Directors is asked to: approve the bi-annual staffing review to the Board, confirm it is satisfied of the assurances within the report.

Appendix 2 – Care Hours per Patient Day (CHPPD)

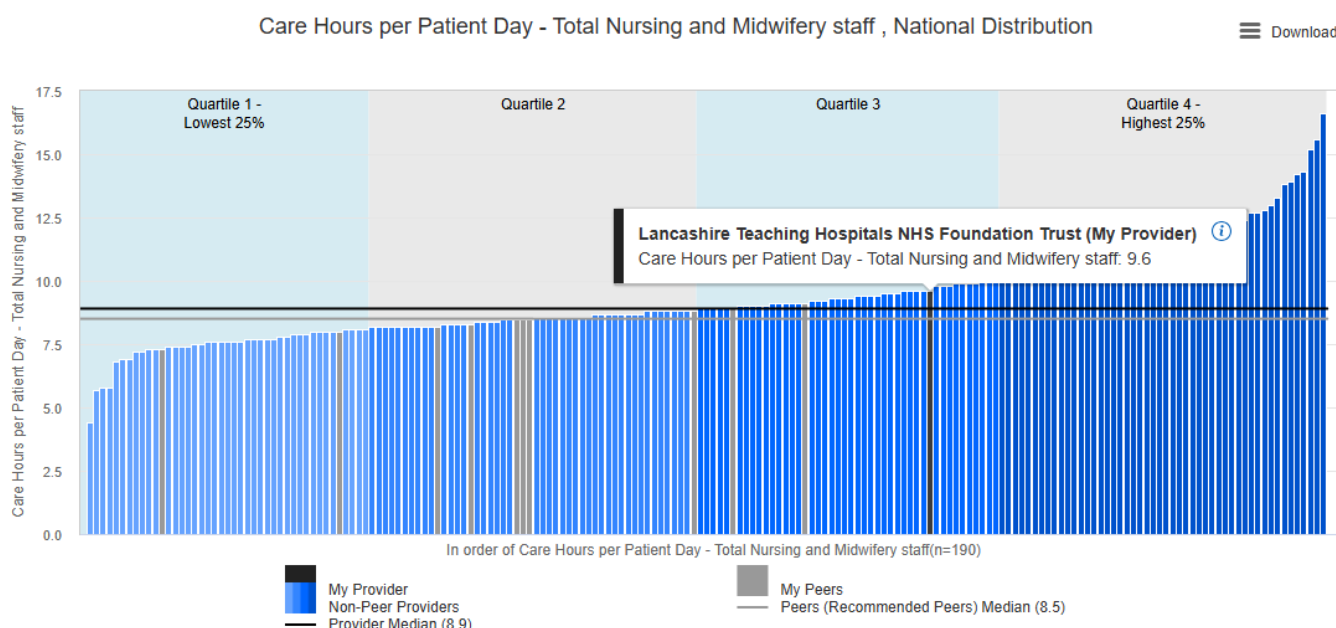
Care Hours per Patient Day (CHPPD) is a national benchmarking measure used to compare the overall level of nursing and support worker staffing against occupied bed days. It should be considered alongside acuity, dependency, patient flow, service configuration and professional judgement, rather than as a standalone measure of staffing adequacy.

Lancashire Teaching Hospitals reports a CHPPD value of 9.6, placing the Trust within the third quartile nationally and in line with a number of comparable acute and tertiary providers. The position is consistent with organisations delivering complex and specialist services, where higher levels of dependency and acuity require increased staffing input.

Benchmarking demonstrates that the Trust is comparable to other large teaching hospitals including Northern Care Alliance (9.6), Manchester University NHS Foundation Trust (9.6) and Liverpool University Hospitals (9.8). This supports the conclusion that staffing establishments remain aligned to the complexity of services provided.

As CHPPD does not account for patient acuity, enhanced care requirements, ward layout or operational pressures, assurance regarding staffing levels continues to be derived through triangulation with SNCT, Birthrate Plus, quality indicators and professional judgement.

Model Hospital Lancashire Teaching using CHPPD – April 2026



CHPPD compared to Northwest Region and Recommended Peer Organisations. (April 2026)

Organisation Name	Organisation Value	Peer	Quartile
Mid Yorkshire Teaching NHS Trust	7.3	Yes	Quartile 1
Countess of Chester Hospital NHS Foundation Trust	7.4	No	Quartile 1

East Lancashire Hospitals NHS Trust	7.6	No	Quartile 1
Mersey and West Lancashire Teaching Hospitals NHS Trust	7.7	No	Quartile 1
Blackpool Teaching Hospitals NHS Foundation Trust	7.7	No	Quartile 1
Wirral University Teaching Hospital NHS Foundation Trust	7.9	No	Quartile 1
Torbay and South Devon NHS Foundation Trust	8	Yes	Quartile 1
East Cheshire NHS Trust	8.1	No	Quartile 1
Royal Cornwall Hospitals NHS Trust	8.2	Yes	Quartile 2
Mid Cheshire Hospitals NHS Foundation Trust	8.2	No	Quartile 2
Sherwood Forest Hospitals NHS Foundation Trust	8.3	Yes	Quartile 2
Dudley Group NHS Foundation Trust	8.5	Yes	Quartile 2
University Hospitals Coventry and Warwickshire NHS Trust	8.5	Yes	Quartile 2
North Bristol NHS Trust	8.5	Yes	Quartile 2
Pennine Care NHS Foundation Trust	8.6	No	Quartile 2
Tameside and Glossop Integrated Care NHS Foundation Trust	8.7	No	Quartile 2
North Cumbria Integrated Care NHS Foundation Trust	8.8	Yes	Quartile 2
London North West University Healthcare NHS Trust	8.9	Yes	Quartile 3
University Hospitals of Morecambe Bay NHS Foundation Trust	9	No	Quartile 3
East Kent Hospitals University NHS Foundation Trust	9.1	Yes	Quartile 3
Stockport NHS Foundation Trust	9.1	No	Quartile 3
Bolton NHS Foundation Trust	9.3	No	Quartile 3
Northern Care Alliance NHS Foundation Trust	9.6	No	Quartile 3
Lancashire Teaching Hospitals NHS Foundation Trust	9.6	Yes	Quartile 3
Manchester University NHS Foundation Trust	9.6	No	Quartile 3
Liverpool University Hospitals NHS Foundation Trust	9.8	No	Quartile 4

Wrightington, Wigan and Leigh NHS Foundation Trust	9.9	No	Quartile 3
Cheshire and Wirral Partnership NHS Foundation Trust	9.9	No	Quartile 3
Walton Centre NHS Foundation Trust	10.7	No	Quartile 4
Mersey Care NHS Foundation Trust	10.8	No	Quartile 4
Greater Manchester Mental Health NHS Foundation Trust	12.1	No	Quartile 4
Liverpool Heart and Chest Hospital NHS Foundation Trust	12.7	No	Quartile 4

Appendix 3 – Safe Staffing Quality Assurance Dashboard

The Safe Staffing Quality Assurance Dashboard was introduced during this review cycle to strengthen triangulation of workforce, quality, safety and patient experience metrics. The dashboard brings together information relating to staffing, vacancies, sickness, training compliance, patient outcomes, patient experience and professional judgement into a single assurance framework.

The dashboard has supported earlier identification of emerging risks and trends, enabling focused discussion during divisional reviews. Areas demonstrating clusters of concerns across workforce and quality indicators were reviewed in greater detail, allowing targeted action plans and enhanced oversight to be implemented where required.

The introduction of the dashboard has strengthened the Trust's ability to provide evidence-based assurance regarding safe staffing and will continue to be refined as additional metrics and divisional learning are incorporated.

Safe Staffing Quality Assurance Dashboard

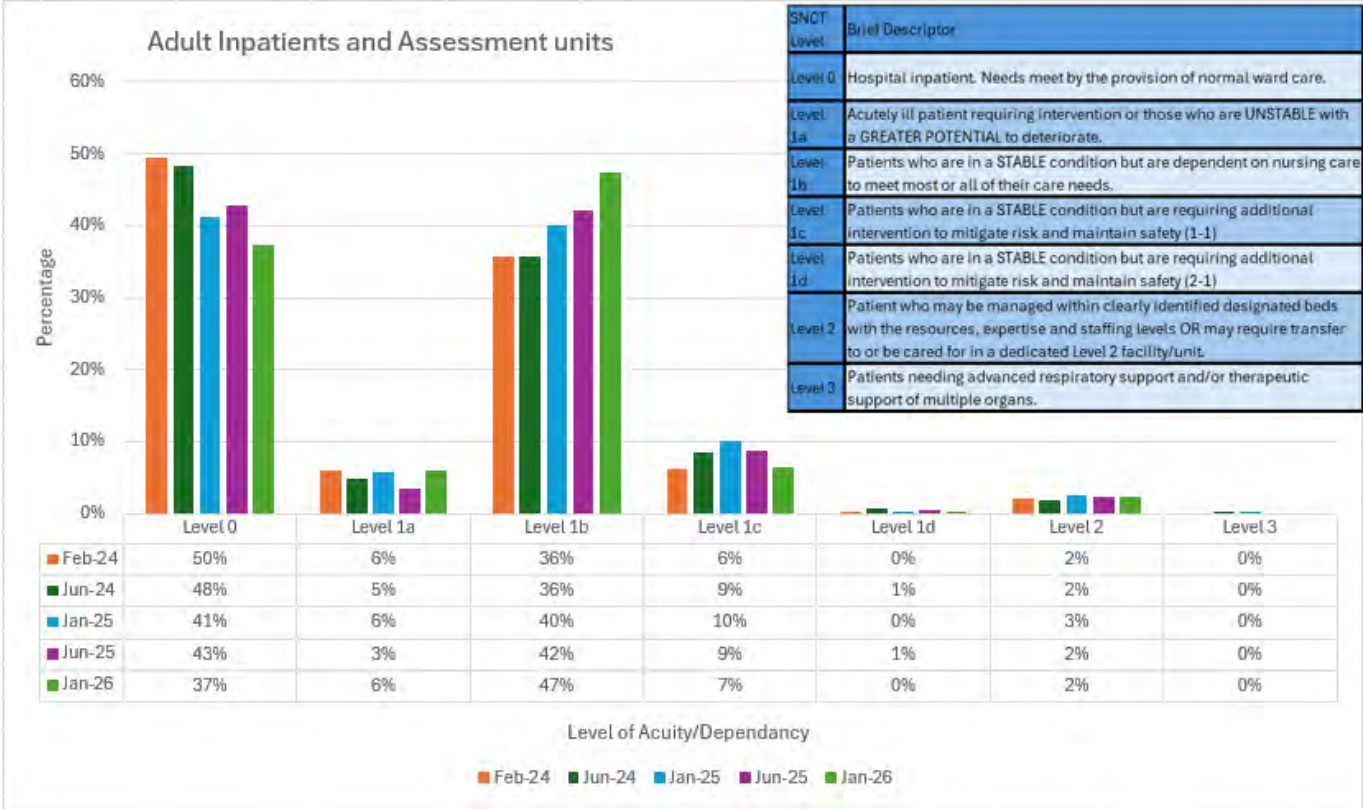


Appendix 4 - Acuity Levels calculated from the validated SNCT tool

Workforce reviews are informed by the twice-yearly formal reviews that include the collection of SNCT data. SNCT has specific criteria that must be evidenced: a license; minimum data collection of 30 days twice a year; 3 senior staff trained for each ward; established external (to the ward) validation; interrater reliability assessment. SNCT data is run through the appropriate software supplied with the license using multipliers that are applied to descriptors.

The graphs below provide a breakdown of the overall SNCT data collected since commencement in February 2024.

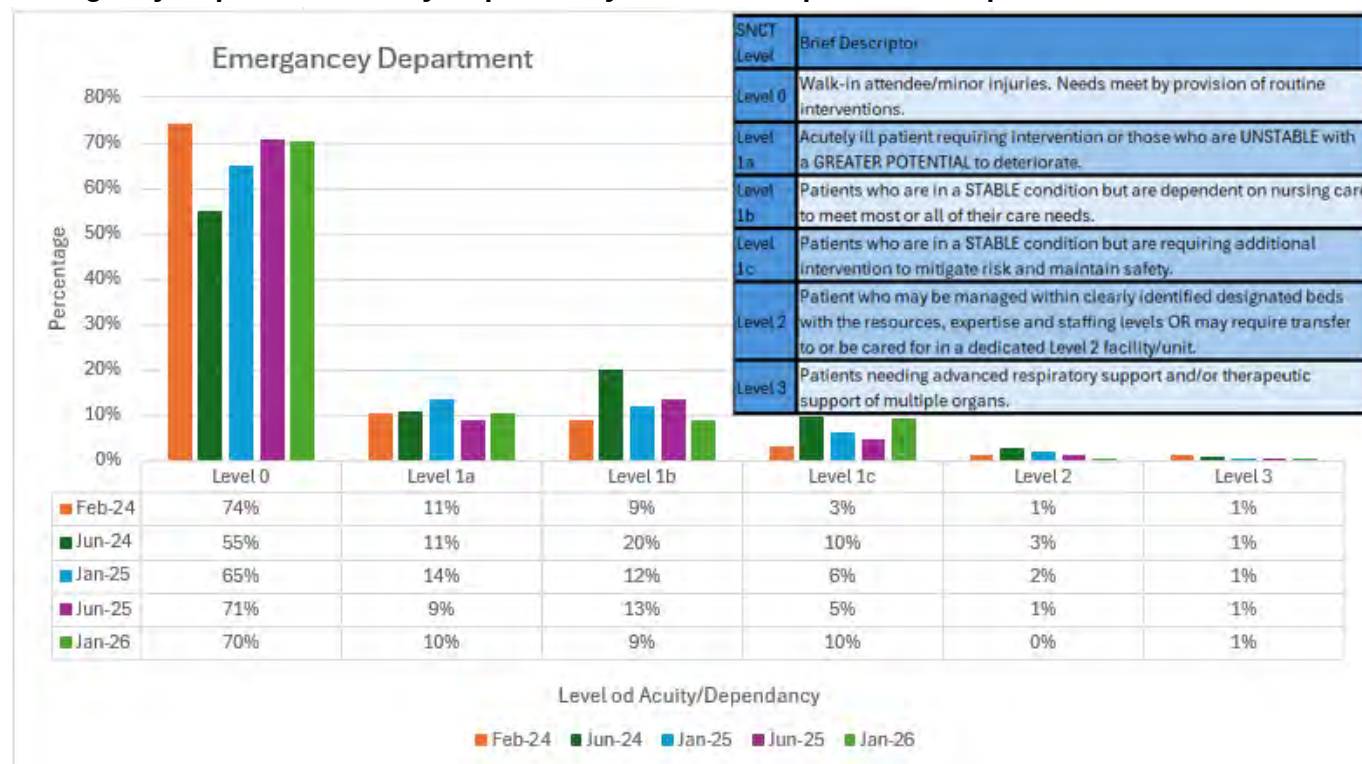
Adult Inpatient and Assessment Unit Acuity/Dependency Levels – Proportional Output.



The Adult Inpatient and Assessment Unit SNCT data demonstrates a gradual increase in the proportion of dependency category 1B patients over the reporting period, indicating a trend towards patients requiring greater levels of nursing support. This finding aligns with themes identified through the divisional reviews, particularly within Medicine and Surgery, where increasing complexity, enhanced care requirements and patient flow pressures were reported.

Despite increasing dependency, triangulation with workforce establishments, quality indicators and professional judgement has confirmed that staffing remains safe overall. Areas demonstrating sustained increases in acuity continue to be monitored through routine workforce reviews and establishment assessments.

Emergency Department Acuity/Dependency Levels – Proportional Output.

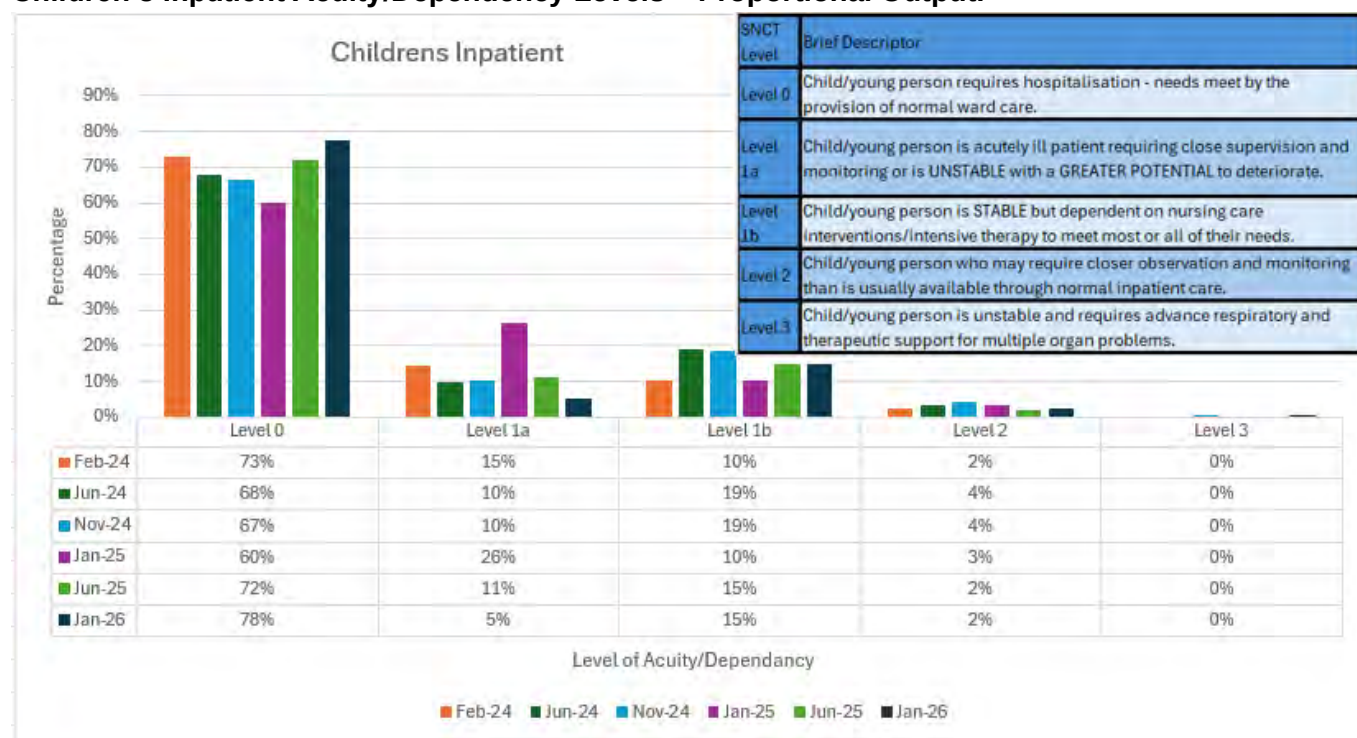


Emergency Department acuity and dependency remains variable and is influenced by fluctuations in attendance, patient flow and the increasing number of patients experiencing extended lengths of stay within emergency care settings. Traditional SNCT methodology has recognised limitations in fully reflecting these operational pressures.

The recent enhancement to the emergency care SNCT methodology, which incorporates staffing requirements for patients remaining within the department for more than 12 hours, is expected to provide a more representative assessment of workforce requirements. This will be incorporated into future reviews and support continued refinement of establishment assessments.

Professional judgement remains particularly important within Emergency Departments and continues to provide assurance that staffing requirements are being appropriately assessed alongside operational and performance measures.

Children's Inpatient Acuity/Dependency Levels – Proportional Output.



Children's inpatient acuity and dependency data demonstrates relative stability across the review period. Following the increase observed during January 2025, acuity levels have returned to expected ranges, suggesting this represented a period of temporary variation rather than a sustained change in demand.

The overall proportional split across acuity and dependency categories has remained broadly consistent, supporting the conclusion that current funded establishments remain appropriate. This is consistent with the findings of the Children's divisional review, which concluded that staffing levels remain safe when considered alongside professional judgement, RCN and quality indicators.

11.1C BI-ANNUAL AHP STAFFING REPORT

☐ Other

Item for assurance

REFERENCES

Only PDFs are attached



11.1c Bi-Annual AHP Staffing Report Ancillary Board Pt I October 2026.pdf

Meeting of the	Board of Directors	01 October 2026	
Title of Report	Allied Health Professionals Bi-annual Safety & Quality Review		
Report Author	Claire Granato – Chief Allied Health Professional		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer and Deputy Chief Executive		
Recommendation/ Actions required	The Board of Directors are asked to: I. Receive this report and confirm it is satisfied of the assurances for AHP safe staffing II. Support the continued development of the digital AHP safe staffing dashboard		
	Decision ☐	Assurance ☒	Information ☐

Appendix 1 – Ancillary Pack – Full Report

1. Introduction

This report details the findings of the Lancashire Teaching Hospitals (LTH) Allied Health Professionals (AHPs) staffing review, for the reporting period January 2026 to June 2026. This report is in response to the 2018 'Developing Workforce Safeguards' recommendations and the National Quality Board guidance. It also meets the recommendations in relation to the AHP governance arrangements from the 2019 NHSE/I 'Guide to Reviewing AHP Leadership for Trust Boards and Clinicians'.

The review triangulates workforce information with safety and quality indicators in order to provide assurance of safe staffing levels within the AHP services.

There is currently no specific tool to define AHP safe staffing, therefore professional judgement and national/local benchmarking are utilised. Three clinical specialities do have workforce guidelines covering Physiotherapy, Occupational Therapy, Dietetics and Speech and Language Therapy. These include Critical Care, Stroke and Neonatal Intensive care, compliance against guidelines for these areas will be reported annually in the August report.

For this period the report has been developed to provide an overall Red Amber Green (RAG) rating for safe staffing assurance for each professional group, for Diagnostic Radiography this is broken down further into specialist modalities (due to budget structures). In the absence of national safe staffing guidance, multiple metrics are reviewed to provide the rating.

2. Scope

All 10 Allied Health Professional groups at Lancashire Teaching Hospitals, across both inpatient and outpatient pathways. The 10 professions are; Dietitians, Occupational Therapists, Operating Department Practitioners (ODP's), Orthoptists, Physiotherapists, Prosthetists & Orthotists, Diagnostic Radiographers (including Sonographers), Therapeutic Radiographers and Speech & Language Therapists.

3. Workforce

3.1 Leadership

The Chief AHP is the most senior AHP in the trust and provides clinical, professional and strategic leadership to the AHP services and their leaders, this includes the 9 AHP Professional Leads/Heads of Service and 1 Matron (ODP). The Chief AHP reports to the Chief Nursing Officer.

3.2 Specialist and Advanced AHP Roles

Table 1 – Specialist and Advanced AHP Roles 2021-2025

Role	Year/Number					
	2021	2022	2023	2024	2025	2026
Consultant AHP	7	8	8	9	8	8
Advanced Clinical Practitioner (Trainee and qualified)	12	12	17	18	18	19
Research	2	3	3	1	0	0
Other roles (where being an AHP is not part of the essential criteria)	6	7	9	9	10	10
Total	27	30	37	37	36	37

Table 1 positively evidences AHPs are taking on advanced and Consultant practice roles in the organisation and crossing professional boundaries. With the numbers static over the past 3 years as the roles have become embedded. The Trust also has a number of AHPs employed in roles where being AHP is not an essential criterion, evidencing that AHPs are supported to progress their careers in previously non-traditional areas.

Over the past 5 years there has been a reduction of AHPs working within the research department, this is reflective of less secondment opportunities and the financial challenges for the department. However, AHPs are contributing to the research agenda at every level and those in advanced and consultant roles have protected time to deliver the research pillar of advanced practice.

These metrics are a core component of developing services of the future whilst maximising the offer of AHPs in shaping services delivered through an evolving and multi-professional team. Positively, all 10 professions are represented within the current 36 posts in table 1.

3.3 Workforce Metrics

The following workforce metrics are taken from the Electronic Staff Record (ESR). Previously an ESR cleanse was completed, providing assurance that our AHPs are aligned to the correct occupational codes.

There are 2 limitations of the ESR data set for AHPs, firstly the Prosthetist and Orthotists cannot be split out as they have the same occupational code. Secondly, the ODP data does not accurately describe establishment/vacancy as any vacant posts are advertised to Nurses and ODP's and budget lines then moved around dependent on the recruitment outcome.

Vacancy Rate

The vacancy sweep process has resulted in vacant posts being removed from funded establishments as an agreed action from the Trust Workforce Reduction Program (WRP). This has resulted in a requirement to review the funding allocation across the service. Final decisions on funded establishments will be informed through a full review following the business case process. This is being supported by AHP professional leads to ensure workforce requirements, service risks and operational impacts are fully considered before outcomes are confirmed. In the profession specific vacancy graphs in appendix 1, the last data points (June 2026) reflect the revised funded establishments post sweep.

The following table provides a high-level summary of the funded establishment reductions for each profession.

Table 2 – June 2026 AHP Establishment Reductions Post Vacancy Sweep

Profession	May 26 Establishment (WTE)	June 26 Establishment (WTE)	Reduction (WTE)	Reduction (%) and RAG Rating
Dietetics	30.07	28.38	1.69	5.6
Occupational Therapy	71.78	68.47	3.31	4.6
ODP's	75.55	75.55	0	0
Orthoptics	12.13	11.63	0.5	4.1
Physiotherapy	113.17	105.90	7.27	6.4
Prosthetics & Orthotics	15.05	14.21	0.84	5.6
Diagnostic Radiography	179.35	160.64	18.71	10.4
Therapeutic Radiography	92.35	87.75	4.6	5.0
Speech & Language Therapy	28.52	23.97	4.55	16

Table 2 details an average 5% reduction across professions, with the exception of Diagnostic Radiography (10%) and Speech and Language Therapy (16%). There is no impact to the ODP workforce, as Theatre Practitioners were out of scope for the process.

The vacancy sweep process has had a disproportionate impact on the AHP workforce compared with other clinical staff groups. This is largely due to the absence of nationally agreed safe staffing guidance for most AHP professions, vacancies that were held during the recruitment freeze in late 2025, limited bank/agency resource and the way workforce budgets are structured.

With the exception of Diagnostic Radiography, AHP budgets are generally managed at profession level rather than by specialty. For example, all Physiotherapy posts are held within a single budget code rather than being allocated to individual clinical services. As a result, while the budget may appear to show a sustained vacancy over time, this does not necessarily reflect a vacancy within the same specialty or resulting from the same staff member leaving. This can mask workforce pressures within specific services and may lead to an inaccurate assessment of staffing requirements when vacancy data is reviewed at an aggregated level.

Currently the risk to safe staffing is minimal. While a total of 45.47WTE vacant funded posts have been included in the sweep, some had already progressed through recruitment stages and new starters are planned for September, particularly new graduates in Diagnostic Radiography and Physiotherapy. A clear understanding of the impact and actual establishment reductions will not be gained until the full review has taken place which due to be completed by October with an update to the committee in the next bi-annual report.

Maternity Leave Rate

Table 3 – Maternity Leave by Profession in June 2026 and the January-June Trend

Profession	June 26 WTE	June 26 % of contracted	Trend (last 6 months)	RAG Rating
Dietetics	1.16	4	Static	
Occupational Therapy	0.60	0.9	Downward	
ODP's	1.00	1.3	Static	
Orthoptics	4.8	33	Upward	
Physiotherapy	6.59	6.2	Static	
Prosthetics & Orthotics	0	0	Static	
Diagnostic Radiography	7.13	4.4	Static	
Sonography	2.00	7.1	Downward	
Therapeutic Radiography	2.17	2.5	Static	
Speech & Language Therapy	0.80	3.6	Downward	

During this reporting period, maternity leave has had a significant operational and clinical impact on the Orthoptics service. In June 2026, 33% of the Orthoptic workforce was on maternity leave, creating considerable workforce pressures. To maintain service delivery, comprehensive cover arrangements were implemented, including the use of bank Orthoptists to support training and induction ahead of planned absences.

These workforce pressures have contributed to higher than usual variable pay expenditure within Orthoptics (Table 5). As part of mitigating this increased spend and strengthening workforce stability, two bank positions have subsequently been converted to fixed-term contracts.

In contrast, the Sonography workforce has experienced a 50% reduction in maternity leave compared with the previous reporting period. This has improved workforce capacity within the service and has contributed positively to addressing the operational and performance challenges previously reported.

Absence Rate

Table 4 – Absence by Profession in June 2026 and the January-June Trend

Profession	June 26 WTE	June 26 %	Trend (last 6 months)	RAG Rating
Dietetics	1.03	3.6	Static	
Occupational Therapy	5.52	8	Downward	
ODP's	10.72	13.6	Upward	
Orthoptics	0.41	2.8	Downward	

Physiotherapy	2.82	2.6	Static	
Prosthetics & Orthotics	0.37	2.6	Static	
Diagnostic Radiography	7.58	4.6	Static	
Sonography	0.16	0.57	Downward	
Therapeutic Radiography	5.87	6.7	Static	
Speech & Language Therapy	0.70	3.1	Static	

Absence rates in June 2026 for 7 AHP groups are meeting the Trust target and are rated green in table 4. Table 9 breaks down absence rates in Diagnostic Radiography into modalities, whilst overall they are meeting targets, it does show MR and Nuclear Medicine as hotspot areas.

ODP's are the main area of concern, with a deteriorating trend since December 2025 (9.31WTE). The Theatres SBU are focussing on sickness absence utilising the new policy.

Therapeutic Radiography and Occupational Therapy are rated amber, upon a deeper dive, in Occupational Therapy no patterns/trends were identified and there is a mixture of long-term and short-term absences. However, in Therapeutic Radiography, there are a number of absences linked to an ongoing disciplinary process, which will resolve August.

3.4 Overtime, Bank and Agency Use

Table 5 – June 2026 WTE of Overtime, Bank and Agency

Profession	Jun 26 Overtime (WTE)	Jun 26 Bank (WTE)	Jun 26 Agency (WTE)
Occupational Therapists	0.70	0.09	
ODP's	0.06	3.83	
Orthoptists	0.14	1.43	
Physiotherapy	0.18	0.06	
Diagnostic Radiographers (including Sonography)	4.75	0.61	3.52
Therapeutic Radiographers	0.19	0.56	
Speech and Language Therapy	0.09	0.06	
Total	6.11	6.64	3.52

Similar to the last report overtime and bank are main sources of variable pay. There is an identified gap in AHP bank services, usage would be higher if the service was centrally managed.

A total of 7 AHP areas used bank/overtime in June, the majority are minimal and to cover critical rota gaps or weekend provision (Core Therapies). The largest use is in Diagnostic Radiography correlated with vacancy and Orthoptics correlated with maternity leave.

The current AHP agency market is poor, even with approval to use, often no candidates can be sourced. In December 2025 the only agency user was Diagnostic Radiography this is linked to the issues in the Sonography workforce.

4. Model Health Benchmark – Delivering Value for Money

Model Health can be utilised to nationally benchmark some of our AHP workforce. It does have some limitations in that the AHP establishment data can only be filtered down the following professions: Dietetics, Occupational Therapy, Physiotherapy, Speech and Language Therapy, Diagnostic Radiography and

Therapeutic Radiography. It cannot be used to specifically benchmark Orthotics, Prosthetics, Orthoptics or ODP's.

In table 8 in section 7, the model health data for the national distribution of AHP full time equivalents (FTE) has been used the benchmark resourcing at LTH. The national distribution places each Trust in a quartile, 1 being the lowest and 4 being the highest.

This benchmark evidences the following areas of concern:

- Physiotherapy – quartile 1 (lowest)
- Occupational Therapy – quartile 2

Indicating a return on investment for these 2 professions may yield productivity benefits. The largest return on investment would be in Physiotherapy, where the current resource benchmark is in the lowest quartile. Due to LTH being a provider of specialist services both locally and regionally, we would expect to be in quartiles 3 and 4 for all AHPs, recognising that specialist services such as Major Trauma, Neurosurgery and Vascular require significant AHP input throughout the pathway.

5. Training Compliance

Table 7 in section 7, provides an overview of AHP training compliance, along with RAG ratings. This demonstrates full compliance with mandatory training and just 4 areas with non-compliance for appraisal. These are Prosthetics and Orthotics (86%), Intervention (88%) and Neuro-intervention (88%) in Diagnostic Radiography and Therapeutic Radiography (88%), all have plans in place to recover this as soon as possible.

6. Governance

6.1 Safety Triangulation Accreditation and Review (STAR) Quality Assurance

Findings from the recent STAR Quality Assurance accreditation visits are highlighted in table 7 section 7. Of the 10 AHP groups 9 are part of the accreditation process, with 13 AHP departments accredited.

During the reporting period, all gold areas, with the exception of one service, retained their gold accreditation. Core Therapies RPH reduced from gold to bronze due to a failing within critical standards (1 budget code non-compliant for mandatory training).

6.2 Risk

There are currently 8 active AHP workforce risks on the Trusts risk register (see table 6). There is one new risk (2280) linked to the high vacancy rate (band 6) in Diagnostic Radiography and four risks have been recommended for closure and is detailed in table 7.

Diagnostic Radiography (Ultrasound and Chorley Services) is the highest risk profession, with 2 risks scoring 15, this triangulates with the high vacancy rates seen pre-vacancy sweep in May (19.92WTE).

Table 6 – AHP Workforce Risk Overview

ID	Title	CBU	Current Score	Date of last review	Direction of score since last report	Action Plan
1193	Loss of ultrasound service due to lack of staffing	Diagnostic Clinical Business Unit - Trustwide	15	15/05/2026	↑	• RRP Paper • Business case being written as per PWC demand and capacity modelling • Recruit trainees with UoC

2280	Inability to provide full service within CDH radiology due to band 6 staffing issue	Diagnostic Clinical Business Unit - CDH	15	N/A	NEW	• Recruit to band 6 Radiographer positions
1351	Reduced SLT Service to Workforce Pressures	Acute & Specialist Surgery - Trustwide	12	15/06/26	↑	• Continue to recruit to vacancy • Outpatient service review • Implement cross-specialty prioritisation SOP
2068	Radiographic staffing level in the Radiotherapy Department (falling below requirements to meet clinical demand)	Oncology, Head & Neck Clinical Business Unit - RPH	12	18/06/26	↑	• Business case to be submitted
2008	Inability to provide a 7-day scanning provision for early pregnancy patients as per NICE guidelines & the pregnancy loss review	Women's Services - RPH	12	24/04/26	→	• Capacity / Demand scoping exercise • MDT review of SOP
1818	Inability to meet inpatient service need in Core Therapies due to staffing constraints	Psychology & Therapies – RPH	10	22/05/26	→	• Complete capacity and demand piece of work across the whole service to provide clarity on the resource gap • Include inpatient performance on Divisional F&P reporting for oversight of unmet need
1443	Delayed listing of orthoptic appointments	Oncology, Head & Neck Clinical Business Unit - CDH	8	17/04/26	→	• Organise coding of appointments to ensure patients are correctly added to the waiting list • Orthoptics Team to review and prioritise patients on the waiting list
1007	Orthotic Clinical Management. Excessive Waiting Times	Trauma – PBC	6	29/05/26	→	• Review and re-submit the business case for consideration

Table 7 –Controlled Risks

ID	Title	Updated position
1967	Insufficient substantive radiographers to staff the CT scanner service	Controlled and closed – recruitment complete
1982	Inability to provide standard x-ray service due to Radiographer vacancies	Controlled and closed – recruitment complete
2040	Inability to provide a nuclear medicine service due to staffing levels	Controlled and closed – Long-term sick gap being managed and no incidents
2205	Inability to provide a full CDC Radiology Service due to Movement of Staff to the Acute Sites	Controlled and closed – no new incidents

6.3 Incident Themes

There was a total of 216 AHP workforce incidents reported between January 2026 and June 2026, 196 incidents were level 1 (no harm), 19 were level 2 (low harm) and 1 was level 3 (moderate harm). 205 of the incidents are now closed and 11 are being reviewed.

The 1 moderate harm incident is linked to the Core Therapies Burns and Plastics service, where clinic capacity resulted in a delay to fitting pressure garments to a burns victim, this resulted in worsening of scar tissue and outcomes for the patient.

The 19 low harm incidents are due to the following workforce issues:

- Radiographer absence in Interventional Radiology on-call service impacting the out of hours thrombectomy service

- No diagnostic support worker allocated to Ultrasound in Sumner Suite (due to rota gaps), meaning no chaperone for patients and an inefficient process and list for the Sonographer
- 2 incidents are related to inpatient therapy resourcing and delayed discharges
- 15 incidents are related to capacity in the Core Therapies Hand Service, where post-operative appointments are not within agreed time frames, impacting recovery and outcomes

In comparison to the last report to the committee workforce shortages remain the predominant theme underpinning incident reporting. Reasons for the shortages are cited as unfilled vacancies, sickness absence, maternity leave and under resourced teams. Speech and Language Therapy have improved their reporting culture, ensuring accurate unmet need is captured against risk 1351.

Table 9 (Dashboard) in section 7 displays a full breakdown of incident numbers by professional group.

7. Assurance of Safe Staffing

Table 9 – AHP Safe Staffing RAG Rating and Dashboard

RAG	Definition	Indicators
	Significant staffing pressures and limited ability to mitigate the risk	- Significant staffing shortages - Moderate or severe harm incidents attributed to staff shortages - Limited ability to mitigate high scoring risks
	Staffing pressures, majority of risks mitigated, some concerns	- Vacancies and other leave causing reduced capacity - Incidents reported associated with staff shortages, but low harm - Risks linked to workforce but mitigated
	Safe staffing levels, no significant risks	- Planned staffing levels achieved - Minimal or no incidents attributed to staff shortages - No or low scoring workforce related risks on the register

AHP Group	Patient Harm (incidents) Jan-June 2026				Risk Register	Model Health	Training Compliance June 2026		Workforce Metrics June 2026			Accreditation June 2026	Overall RAG
	No Harm	Low Harm	Mod Harm	Severe Harm	Workforce Risks	FTE Quartile	Appraisal %	Mandatory %	Vacancy %	Sickness WTE %	Maternity WTE	STAR Rating	
Dietetics	0 	0	0	0	No 	3 	90 	95 		1.03WTE 3.6% 	01.16 		
Core Therapies	39 	17	1	0	Yes x1 							Bronze RPH Gold CDH	
Occupational Therapy						2 	96 	98 		5.52WTE 8% 	0.60 		
Physiotherapy						1 	94 	98 		2.82WTE 2.6% 	6.59 		
ODP's	1 	0	0	0	No 	2* 	95 	98 		10.7WTE 13.6% 	1.00 		

Orthoptics	0	0	0	0	Yes x1	2*	92	99		0.41WTE 2.8%	4.8	Gold	
Prosthetics & Orthotics	0	0	0	0	Yes x1	2*	86	98		0.37WTE 2.6%	0	Gold	
Diagnostic Radiography	24	2	0	0		3							
CT (Main)					No		100	99		4.51WTE 9.9%	1.00	Silver	
Intervention					No		88	99		0.55WTE 2.8%	2.00	Gold	
MR (Main)					No		95	98		3.02WTE 7.7%	1.00	Gold	
Neuro-intervention					No		88	99		0WTE 0%	0	Gold	
Nuclear Medicine					No		100	100		0.8WTE 11.2%	0	Gold	
Ultrasound (SGU)					Yes x2		100	100		0.16WTE 0.5%	2.00	Gold	
X-ray CDH					Yes x1		100	97		1.31WTE 3.4%	1.00	Gold	
X-ray CDC & RPH					No		95	96		2.25WTE 3.5%	2.00	Gold	
Therapeutic Radiography	0	0	0	0	Yes x1	4**	88	97		5.87WTE 6.7%	2.17	Gold	
Speech & Language Therapy	132	0	0	0	Yes x1	3	91	100		0.70WTE 3.1%	0.80	Gold	

*'Other AHP' grouping on Model Health, unable to determine red/amber/green

**Limited similar peers, all similar sized Cancer Centres are quartile 4

Table 9 is the AHP safe staffing dashboard, based on the Nurse safe staffing dashboard which is now live in digital format. A digital AHP dashboard is in the process of being built, based on the above metrics and be utilised in future reports during 2027.

The dashboard provides an overview of AHP workforce, safety and quality metrics, along with an overall RAG rating for the professional group. In this report the vacancy column is greyed out due to the ongoing vacancy sweep process, resulting in inaccurate vacancy data for June 2026.

Diagnostic Radiography has been rated as amber overall, due to a number of reasons. In ultrasound, although the workforce position is improving, demand exceeds capacity daily and there are 2 risks on the risk register. CT and Nuclear Medicine have high sickness absence rates and lastly the professional group has been disproportionately impacted by the vacancy sweep, with nearly 19WTE posts removed.

There are 4 more amber rate professions; Physiotherapy is amber due to their quartile 1 Model Health position and having a risk on the register. Occupational Therapy is amber for the same risk alongside a high sickness absence rate impacting availability of the workforce and a quartile 2 Model Health position. Orthoptics are amber rated due to being a small professional group (12.48WTE) and having 4.8WTE on maternity leave. Lastly, Speech and Language Therapy are amber due having a risk on the register with 132 linked incidents alongside being disproportionally impacted by the vacancy sweep, with a 16% reduction to their workforce funding (4.5WTE).

During this reporting period no professions are rated red, the remainder are green.

8. Conclusion

This report details the findings of the LTH bi-annual AHP workforce review to provide an overview of the developing mechanisms in place to assess AHP safe staffing.

Highlights from the report include:

- Sustained improvement in training compliance across the majority of areas
- 10 gold star AHP departments
- No severe harm incidents attributed to the AHP workforce
- Risk maturity - risks reviewed regularly, action plans in place and 4 recommended for closure
- Positive benchmark position in Model Health for Dietetics, Diagnostic Radiography, Therapeutic Radiography and Speech and Language Therapy.

- Improved overall position seen in the Sonography workforce, although demand still exceeds capacity, sickness absence has reduced from 7% to 0.5% and maternity leaves have reduced from 5WTE to 2WTE.

Areas for continued oversight and development include:

- The vacancy sweep process and AHP impact
- Sonography workforce strategy and associated business case led by DCS Division
- Invest to save opportunities within Physiotherapy and Occupational Therapy
- Sickness absence rates in ODPs, Therapeutic Radiography, CT and MR

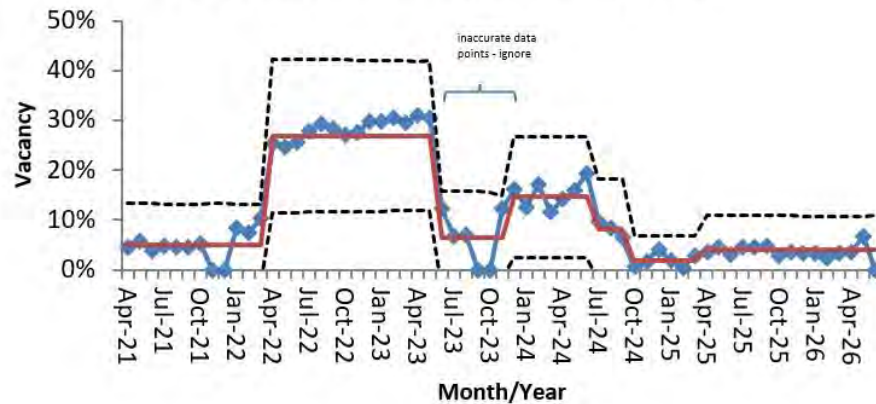
9. Recommendations

It is recommended that the Board of Directors:

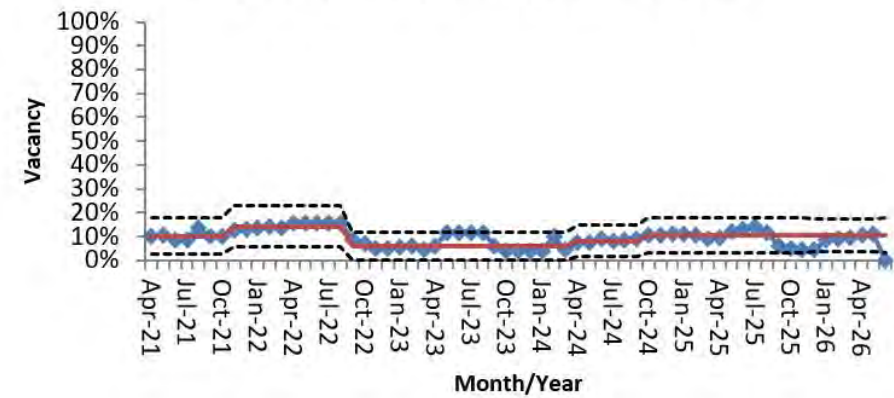
- I. Receive this report and confirm it is satisfied of the assurances for AHP safe staffing
- II. Support the continued development of the digital AHP safe staffing dashboard

Appendix 2 – AHP Vacancy SPC Charts

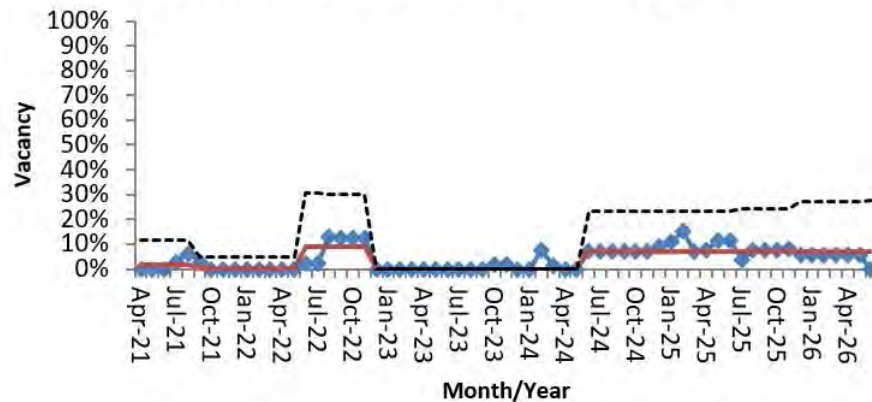
Occupational Therapy Vacancy Rate



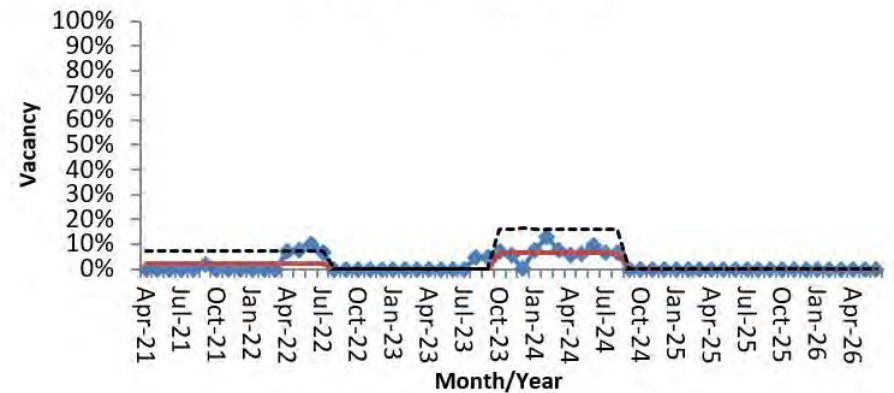
Radiography (Diagnostic) Vacancy Rate



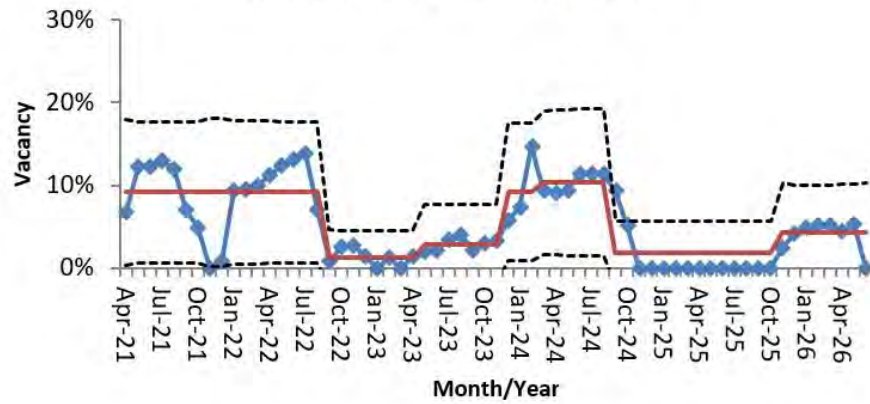
Prosthetics & Orthotics Vacancy Rate



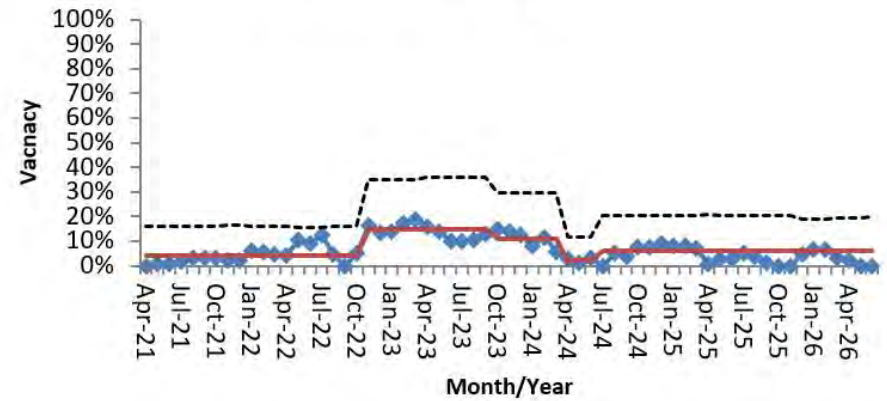
ODP Vacancy Rate



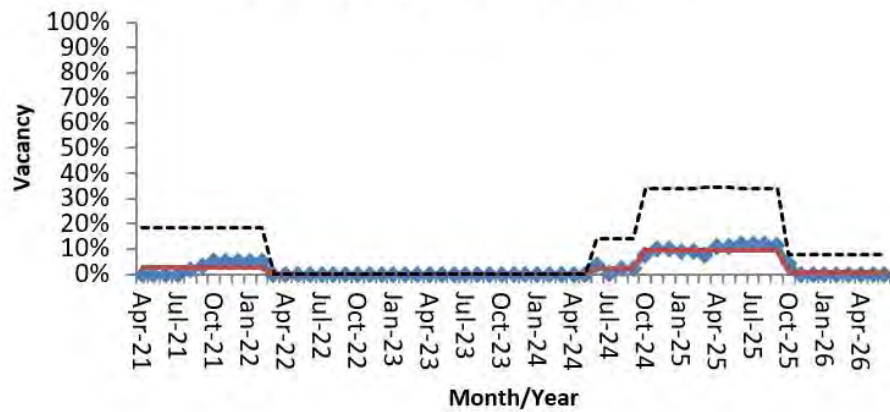
Physiotherapy Vacancy Rate



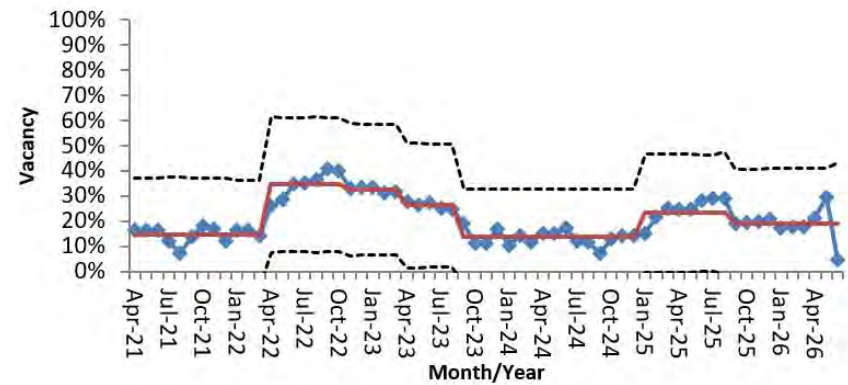
Dietetics Vacancy Rate



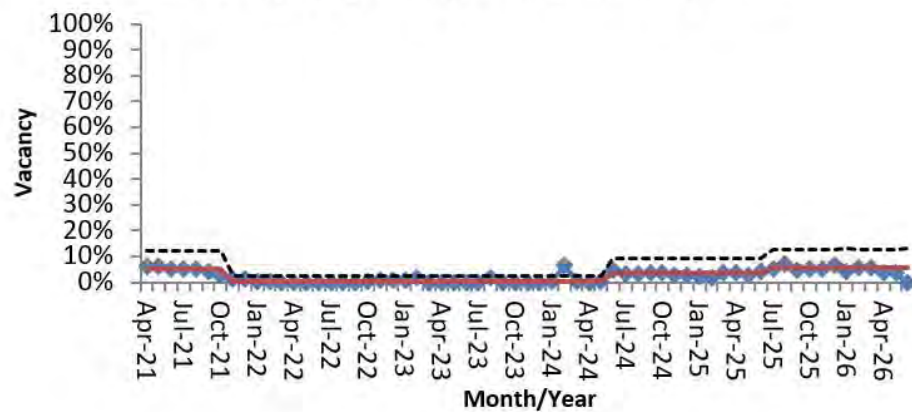
Orthoptics Vacancy Rate



Speech & Language Vacancy Rate



Radiography (Therapeutic) Vacancy Rate



Appendix 3

AHP Safety and Quality Action Plan – June 2026

Key	
Delivered	
On Track	
Overdue/Risk to delivery	

Number	Report Section	Area of Concern	Required Action	Date to be Completed	Lead(s) Responsible	Update	RAG
1	3.3	Vacancy sweep across all professions (except ODP)	- Engage in Trust process - Assess impact of not re-instating posts - Complete and contribute to divisional business cases	Aug 26	All AHP Leads	All actively engaged in the process and being supported by Divisional Directors	
2	3.3	Absence rates across areas are higher than acceptable in: - ODPs - Occupational Therapy - MR - CT - Therapeutic Radiography	- Targeted improvement work - Application of new policy - Explore any themes	Oct 26	AB AT KC GC	- No themes identified except Therapeutic Radiography (extra support provided) - Processes being adhered to	
3	7	Resourcing in Core Therapies and Model Health benchmark position	Explore invest to save business case opportunities	Jan 27	CG SM	- Recent success for Ward 17 Frailty - Wider Frailty business case in draft	

4	7	AHP manual dashboard	Complete build of the digital AHP safe staffing dashboard	Dec 26	BI team CG	- Build commenced - NJ supporting On track for completion end of 2026	
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11.1D HEALTH AND SAFETY ANNUAL REPORT

● Other

Item for assurance

REFERENCES

Only PDFs are attached



11.1d Health and Safety Report Ancillary Board Pt I October 2026.pdf

1. Background

1.1 The purpose of this paper is to provide the Board of Directors with oversight and assurance on the Trust's health and safety governance arrangements, statutory compliance position, risk profile and key improvement priorities for the period November 2025 to August 2026 (covering the period since the last update to Safety and Quality Committee). The report has been scrutinised by the Safety and Quality Committee and is presented to the Board to support oversight of the progress made, the residual risks that remain, and the further work required to strengthen assurance and delivery. The paper also reaffirms the Trust's commitment to meeting its statutory obligations under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 and associated legislation and regulations. The Chief Nursing Officer is the lead executive for health and safety compliance and assurance, with the Chief People Officer retaining responsibility for the People function and the Chief Finance Officer retaining responsibility for estates and facilities.

2. Discussion

2.1 Health and Safety Governance

- 2.1.1** The Trust continues to oversee health and safety through the Health and Safety Governance Group, which meets monthly. Monthly meetings have strengthened engagement, improved representation, enhanced oversight of statutory compliance and improved oversight of local risk management. The Group is chaired by the Associate Director of Risk and Assurance, supported by Estates and Facilities colleagues, the Health and Safety Team, subject matter experts and the Health and Safety Partnership Union Officer, and reports directly to the Safety and Quality Committee and, through it, to the Trust Board.
- 2.1.2** The Health and Safety Governance Group provides corporate oversight of the Trust's health and safety agenda, ensuring that systems are in place to identify, assess and manage risks that may impact patients, staff, visitors and the organisation. The Group monitors compliance with statutory and regulatory requirements, scrutinises health and safety risks, incidents, audits and inspections, and oversees the implementation of actions arising from identified concerns.
- 2.1.3** Alongside these established governance arrangements, the health and safety workstream within the Single Improvement Plan (SIP) continues to provide oversight of the implementation of recommendations arising from the 2025 MIAA review and supports the delivery of continuous improvement across the Trust's health and safety arrangements.
- 2.1.4** As previously reported through the Trust's assurance routes, substantial progress has been made in response to the 2025 Mersey Internal Audit Agency Health and Safety Governance review. Since the audit, the Health and Safety Governance Framework has been significantly strengthened and is now embedded within routine governance arrangements. HSGG has moved from bi-monthly to monthly meetings, supported by a strengthened Cycle of Business, improved escalation arrangements and increased reporting to the Executive Management Team, Safety and Quality Committee and Estates and Facilities Partnership Board.
- 2.1.5** Oversight and monitoring have also been strengthened through the ongoing monthly Health and Safety Report, regular reporting of the Estates and Facilities Statutory Compliance Tracker and a weekly Non-Patient Safety Incident SitRep. These arrangements provide greater visibility of compliance, incidents, emerging risks, themes and trends through triangulation of multiple sources

of intelligence. Whilst health and safety remains an area of continuous improvement, evidence has been provided to MIAA to support closure of the remaining outstanding recommendation. Formal closure remains subject to MIAA review and confirmation. The Trust will therefore continue to progress the remaining improvement work through the Single Improvement Plan and report progress through HSGG and relevant assurance routes.

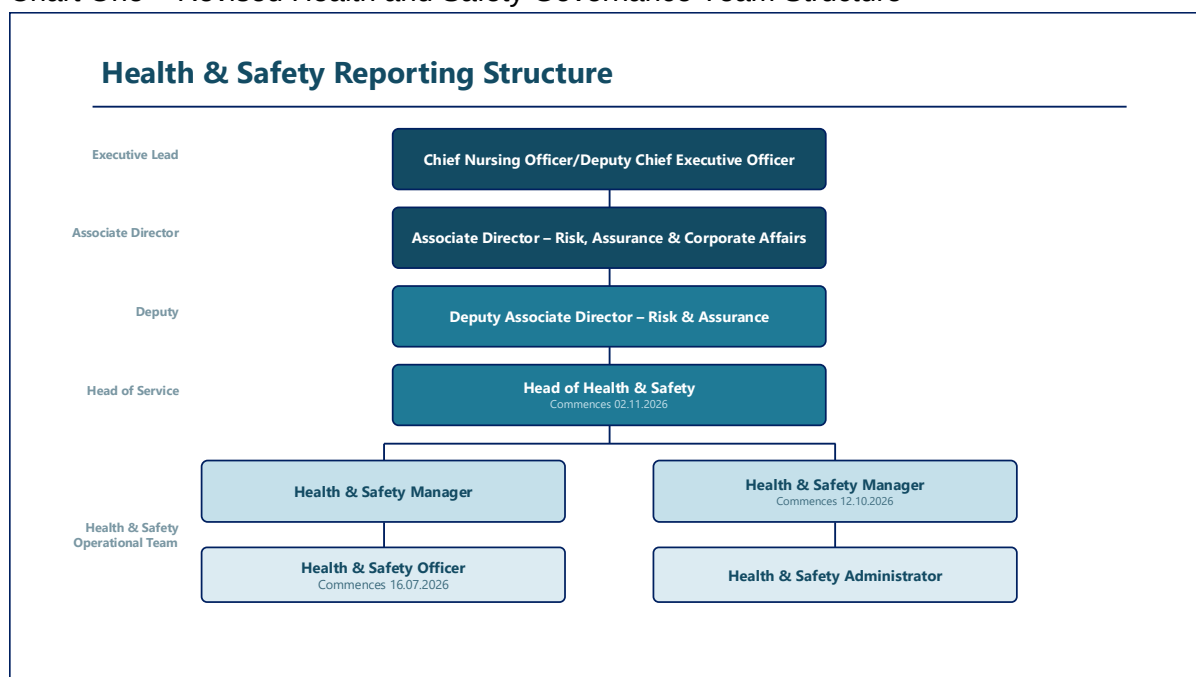
2.1.6 Health and safety policies are maintained within the Trust's document management system, Heritage, which provides version control, audit trails and accessibility for staff. Whilst policies remain available to staff and there have been no significant legislative changes since the previous reporting period, a systematic review and deep dive of the health and safety policy suite is underway and will be progressed on a phased basis as individual health and safety topics and specialist disciplines are reviewed and improvement processes are embedded. This approach will ensure that each policy is considered in context, including alignment with HSG65 standards, statutory requirements, operational practice, ownership, review cycles and monitoring arrangements. This will form part of the wider programme to strengthen health and safety assurance and governance.

2.2 Health and Safety Team Resilience

2.2.1 The 2025 MIAA review identified a vulnerability in the Health and Safety Governance Team. For a prolonged period, the team consisted of a Band 7 Manager and a Band 3 administrator, leaving a single point of failure during the long-term absence of the substantive Band 7 Manager. To address this, a sustainable structure has been developed and financed. Recruitment has now been completed for a Band 5 Health and Safety Governance Officer, who commenced in post in July 2026; a Band 7 Health and Safety Manager, commencing in post in October 2026; and a Band 8a Head of Health and Safety, commencing in post in November 2026. The revised structure is shown in Chart One. Activities have been constrained as a result of limited capacity, although progress is evident.

2.2.2 It is important to recognise that the programme of work remains substantial and complex, with a number of longstanding issues requiring sustained action, targeted investment, cross-divisional ownership and continued executive oversight. The strengthened team will provide the capacity required to move beyond oversight and monitoring into full delivery mode, including increased audit activity, risk assessment support, action tracking, thematic reviews and proactive improvement work across the Trust.

Chart One – Revised Health and Safety Governance Team Structure



2.3 Health and Safety Profile (including Statutory Compliance), Risk Intelligence and Assurance

2.3.1 Health and Safety Profile and Statutory Compliance

2.3.2 Building on strengthened governance arrangements, the Health and Safety Governance Group (HSGG) is focused on triangulating intelligence and understanding the Trust's health and safety profile. This involves combining proactive assurance (audits, compliance monitoring) with reactive intelligence (incident trends and emerging risks) to provide a holistic view of organisational safety and compliance.

2.3.3 The Estates Statutory Compliance Tracker is presented quarterly to HSGG and offers visibility of compliance status against Health Technical Memoranda (HTMs) and other regulatory standards. Compliance with HTMs supports the safe design, installation and operation of specialised building and engineering systems within healthcare environments, supporting infrastructure resilience and high-quality patient care.

2.3.4 Current monitoring has identified compliance risks and improvement requirements across a number of engineering and facilities disciplines. The most significant statutory compliance challenges currently relate to water safety, ventilation systems and low-voltage electrical infrastructure.

2.3.5 Key issues identified through compliance monitoring include outstanding actions arising from Legionella risk assessments, development of the Pseudomonas improvement programme, ventilation assurance and documentation gaps, incomplete fixed wire testing, emergency lighting testing backlogs and elements of the ongoing fire safety remediation programme. These issues are reflected within the Trust's risk profile.

2.3.6 In addition to engineering compliance risks, health and safety risks continue to be identified in areas including food safety, cleaning standards, waste management practices, violence and aggression, environmental conditions, workforce resilience, security challenges and the condition of the ageing

estate. These risks are managed through the Trust's wider governance and risk management arrangements and remain areas requiring ongoing oversight.

2.3.7 Many of the identified compliance challenges are linked to ageing infrastructure, historical maintenance backlog, incomplete inspection programmes, assurance documentation gaps and workforce capacity constraints within operational estates services. Current estimates indicate that approximately £29.35 million of targeted investment is required to address identified statutory compliance deficiencies across water safety, electrical safety, ventilation, fire safety, pressure systems and other HTM-regulated disciplines. Delivery of the first phase of the Statutory Compliance Improvement Programme has been estimated at £7.79 million.

2.3.8 The Statutory Compliance Improvement Programme identifies priority improvement activity relating to water safety, electrical safety, ventilation, fire safety and pressure systems. Delivery priorities, investment requirements and progress continue to be monitored through Estates and Facilities governance arrangements. The presence of mitigation measures does not remove the need for continued investment and action to address the underlying compliance gaps.

2.4 Risk Management

2.4.1 The transition to the Ulysses system has strengthened risk governance by aligning risks to designated oversight groups. As a result, the Health and Safety Governance Group now has enhanced oversight of risks within its remit, enabling improved scrutiny of risk themes, trends, controls and mitigating actions.

2.4.2 The Trust continues to manage a significant and complex health and safety risk profile. As at the end of August 2026, there were 75 active risks associated with the Health and Safety Governance Group. Further details are included in Appendix 1.

2.4.3 The most significant health and safety themes continue to relate to the ageing estate and infrastructure, with multiple risks associated with water safety, fire safety, ventilation systems, electrical infrastructure, deteriorating buildings, windows, roofs, flooring and environmental conditions. These longstanding risks have the potential to impact patient safety, staff wellbeing, service continuity and regulatory compliance. Concerns remain regarding carbon steel pipework failures, degradation of estate infrastructure, water safety management, ventilation systems, fire safety controls and electrical resilience.

2.4.4 Workforce resilience remains a key organisational risk. A new high risk concerning Operational Estates Staffing Gaps was added to the risk register in June 2026, highlighting the potential impact of vacancies on statutory maintenance, preventative maintenance programmes and compliance activities. Staffing challenges also continue within facilities services, where shortages could affect catering, domestic services, portering and infection prevention arrangements. Risks relating to staff safety, violence and aggression, lone working, psychological wellbeing support and Display Screen Equipment compliance also remain under active management.

2.4.5 Environmental and security risks continue to feature prominently, including risks associated with CCTV deterioration, asbestos management, lifts, structural defects, violence and aggression, ligature points, fire safety and security arrangements within clinical areas. Whilst these risks remain significant, mitigation plans, capital investment programmes and strengthened governance arrangements are in place to reduce exposure and improve compliance.

- 2.4.6** Positively, since the last report to the Committee in November 2025, several risks have reduced or been controlled during the reporting period, including risks relating to laboratory ventilation, decontamination processes, lone working, radiation sources, environmental conditions and Building Safety Act requirements. The increase in controlled risks indicates that targeted improvement programmes and risk management actions are beginning to have a positive impact.
- 2.4.7** From October 2026, the Health and Safety Governance Group will commence a structured review of longstanding risks, with a particular focus on the highest-scoring and longest-standing risks. This enhanced scrutiny will support the identification of barriers to risk reduction, provide additional organisational challenge and support, and ensure that robust action plans are in place to facilitate risk mitigation and closure where appropriate.

2.5 Ward and Departmental Health and Safety Risk Assessments

- 2.5.1** A key area of focus for the Health and Safety Governance Group is strengthening corporate visibility of ward and departmental health and safety risk assessments. Whilst risk assessments are undertaken locally, current arrangements do not yet provide consistent central oversight of whether assessments are current, complete, appropriately reviewed and supported by clear action tracking. Options to use Ulysses as a central storage and oversight mechanism were explored; however, this did not provide a suitable solution for the level of monitoring and assurance required.
- 2.5.2** In response, the Health and Safety Team has commenced a programme of targeted deep-dive reviews in higher-risk or priority areas. Initial reviews have included the SAFE Centre and Chorley Birth Centre, where fire risks had previously been identified. A further review is planned within the Emergency Department due to known estate-related risks and ongoing operational pressures.
- 2.5.3** These reviews are intended to test the quality and currency of local risk assessments, assess whether controls are in place and effective, identify gaps in ownership or action tracking, and support local teams to strengthen their arrangements. Learning from the initial reviews will inform the wider approach to ward and departmental risk assessment oversight, including future arrangements for storage, monitoring, escalation and reporting through HSGG.
- 2.5.4** Given previous capacity constraints within the Health and Safety Team and the scale of clinical and non-clinical areas across the Trust, this work will need to be implemented on a phased, risk-based basis. The intention is to establish a proportionate cycle of review over the next 18 months, enabling priority areas to be assessed first, actions and learning to be followed through, and assurance arrangements to be strengthened as team capacity becomes fully established.

2.6 Health and Safety Incident Profile and RIDDOR Compliance

- 2.6.1** The Trust continues to strengthen its approach to health and safety through improved responses to incidents, thorough investigations, and targeted interventions. The Health and Safety Governance Group plays a pivotal role in ensuring appropriate escalation and providing a clear route for organisational learning.
- 2.6.2** Appendix 2 provides the supporting non-patient incident profile for the reporting period, with section 2.6 summarising the key themes, learning and actions being progressed through established governance routes.

- 2.6.3** Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), the Trust has a legal obligation to report certain injuries, occupational diseases, and dangerous occurrences to the Health and Safety Executive (HSE). This process is managed by the Health and Safety Team, with reportable staff incidents divided into five categories.
- 2.6.4** Between 1 November 2025 and 31 August 2026, 6,032 non-patient incidents were reported (See Appendix 2). The predominant health and safety risks identified through non-patient incident reporting relate to workforce pressures, violence and aggression, ageing infrastructure, infection prevention compliance, digital system resilience and occupational safety incidents.
- 2.6.5** Violence and aggression incidents remain a significant health and safety concern. Numerous incidents in the reporting period involved verbal abuse, threats, physical assaults, and aggressive behaviour towards staff. A large proportion of these incidents occurred within Emergency Departments, elderly care areas, assessment units and wards caring for patients with cognitive impairment. The frequency of assault-related incidents highlights the continued risk to staff wellbeing and reinforces the importance of violence reduction, security support and staff safety initiatives. Learning from violence and aggression incidents is reviewed through established governance routes, including HSGG, divisional governance and relevant improvement forums. Current actions include continued monitoring of hotspot areas, targeted security support, review of violence markers and incident response processes, and ongoing work to strengthen staff support, education and de-escalation arrangements. A report has also been presented to Workforce Committee. Going forward, this will be presented to the People and Partnerships Committee.
- 2.6.6** A recurring theme within the incidents reported in the period related to the condition of the estate and operational infrastructure. Incidents included defective heating and ventilation systems, unsafe temperatures, leaking roofs, damaged flooring, lighting failures, electrical faults, equipment failures and concerns relating to the suitability of the working environment. Several incidents highlighted the impact of ageing infrastructure on both operational resilience and staff wellbeing. A fully costed three-year prioritised estates plan has been developed to support a risk-based approach to investment in the ageing estate. The plan is progressing through the Trust's governance arrangements and has been shared with NHS England to support consideration of funding requirements. This provides a structured approach to prioritising critical infrastructure and backlog maintenance; however, confirmation of a long-term funding plan remains outstanding. Delivery priorities, investment requirements and progress continue to be monitored through Estates and Facilities governance arrangements. The presence of mitigation measures does not remove the need for continued investment and action to address the underlying compliance gaps.
- 2.6.7** Staff injuries continue to occur across a range of settings, including sharps injuries, body fluid exposures, manual handling injuries, slips, trips and falls, burns and exposure to hazardous substances. Sharps injuries were a recurrent theme, particularly within theatres and procedural environments. Current actions include reinforcing timely incident reporting, reviewing sharps trends and hotspot areas through the Sharps Safety Group, strengthening traceability where issues are identified, and ensuring learning is shared through existing health and safety governance routes.
- 2.6.8** In the reporting period, 22 incidents were either confirmed as RIDDOR reportable or underwent formal consideration for RIDDOR reporting. The predominant causes were manual handling and moving or lifting activities, slips, trips and falls, and physical assaults by patients. Several incidents were associated with environmental hazards, workplace equipment and violence and aggression, reflecting the themes described in the wider health and safety risk profile.

2.6.9 All RIDDOR cases undergo investigation, with learning considered through relevant processes and governance routes to support continuous improvement and compliance with statutory requirements.

2.6.10 Learning and preventative messages are also communicated through targeted Health & Safety Bulletins. The December 2025 bulletin provided staff with practical guidance on clinical waste segregation, prevention and management of sharps incidents, appropriate use of FM First and the Trust Incident Reporting System for estates issues and safety incidents, and safe use of bariatric equipment for patient transfers. The bulletin also signposts staff to relevant policies, reporting routes and training resources

2.7 Audits and Accreditation

2.7.1 The Health and Safety Team undertakes both proactive and reactive audits across all Trust sites, including monthly internal and external inspections. These audits remain challenging due to the ageing estate but continue to identify hazards and drive improvement.

2.7.2 The Safety Triangulation Accreditation Review (STAR) programme continues to provide valuable assurance regarding health and safety standards across the Trust, whilst identifying a number of recurring themes requiring further improvement. Overall, the majority of assessed standards demonstrate good levels of compliance, particularly in relation to nurse call systems (96.4%), Control of Substances Hazardous to Health (COSHH) storage (96.3%), oxygen and suction availability (91.8%), thickener product storage (92.3%), and emergency door disc openers (100%). Mandatory training compliance has also improved since its inclusion as a critical STAR standard.

2.7.3 Areas requiring continued focus include the maintenance and servicing of clinical equipment (83.5% compliance), management of sharps bins (88.2%), and food safety compliance within patient and staff kitchens (79%). STAR reviews also continue to identify concerns regarding medical device cleaning compliance (67.4%), which remains one of the lowest-performing standards despite improvement work and increased governance oversight. Overfilled sharps bins, inconsistent food labelling, and gaps in cleaning processes continue to present potential health and safety risks that require sustained management attention. Improvement actions are being progressed through targeted feedback to clinical areas, continued STAR monitoring, divisional escalation of recurring themes and specialist governance routes where relevant, including Medical Devices, Infection Prevention Control, Estates and Facilities and Health and Safety.

2.7.4 Significant learning has also emerged regarding environmental and estate-related risks. These include ligature risks, blocked fire exits, damaged flooring, deteriorating ward environments, worn décor and delays in completing repairs. The poor condition of flooring remains a recurring issue and has been escalated through governance processes due to the potential impact on falls risk, infection prevention, patient experience and staff morale. STAR findings indicate that staff have a positive reporting culture and actively identify hazards; however, there are opportunities to strengthen communication regarding repair programmes and escalation processes where remedial actions are delayed.

2.7.5 Overall, STAR findings provide useful assurance that a number of key health and safety controls are embedded across the organisation, whilst also identifying areas where continued improvement is required. Learning from STAR continues to be reported through established governance structures to support ongoing quality and safety improvements.

2.8 External Visits

- 2.8.1** Since November 2025, a range of external health and safety-related inspections and visits have provided independent oversight and assurance on specific areas, while also identifying further improvement requirements. See Appendix 3.
- 2.8.2** The most significant inspection was undertaken by HSE in June 2026, reviewing compliance with the Ionising Radiations Regulations 2017 across Radiotherapy, Nuclear Medicine and Radiopharmacy services. Following the inspection, the Trust received a Letter of Contravention identifying three regulatory breaches relating to medical surveillance, radiation monitoring arrangements and local radiation protection controls. The Trust implemented a comprehensive action plan and subsequently provided assurance to HSE that all required remedial actions had been completed and the identified areas of non-compliance had been addressed.
- 2.8.3** Lancashire Fire and Rescue Service (LFRS) undertook a number of fire safety inspections across Chorley and South Ribble Hospital during April and May 2026. While inspections of the Chorley Birthing Centre and Orthopaedic and Pre-Operative Assessment Department identified a satisfactory standard of fire safety, inspections of Leyland Ward, the Estates Department Building, Dermatology and Diabetes Department, Longton Theatres and Critical Care Theatres identified opportunities to strengthen fire safety arrangements. Key themes included fire compartmentation, fire detection systems, escape route management, control of combustible materials, accessibility of evacuation routes and staff fire safety awareness. HSGG has identified the need to strengthen monitoring of fire action plans, and work is underway with Estates and Divisional colleagues to develop improved tracking and reporting arrangements. An update on the strengthened approach will be brought back to HSGG in November 2026.
- 2.8.4** Additional assurance was provided through the annual Environmental Health Services food safety inspection, which awarded a 5-star hygiene rating with no actions identified, and the annual Griffith & Armour insurance inspection, which concluded successfully with no significant concerns raised.
- 2.8.5** Overall, external inspections during this period provided independent oversight and useful assurance that risks are being identified, escalated and acted upon. They also identified areas requiring continued improvement, particularly in relation to radiation safety and fire safety controls. No enforcement or prohibition notices were issued, and progress against inspection findings will continue to be monitored through established governance arrangements, including the strengthened approach to fire action plan monitoring.

2.9 Training and Competency

- 2.9.1** Training remains a cornerstone of health and safety assurance, underpinning compliance and workforce capability. Core skills compliance across the organisation is consistently high, with August 2026 figures showing Health, Safety and Welfare at 98%, Fire Safety at 96%, Infection Prevention and Control level 1 at 97% and level 2 training at 93%, Moving and Handling level 1 at 97%, level 2 at 92%, and Conflict Resolution at 98%.
- 2.9.2** Beyond core skills, the Trust is strengthening specialist and leadership training to address risks in voluntary roles such as DSE assessors, fire wardens, and moving and handling key movers. Initiatives include enhanced fire safety training, accredited programmes, including Royal Society for the Prevention of Accidents (RoSPA) Safer People Handling Trainers and Emergency First Aid at Work.

2.9.3 A small number of staff currently hold qualifications awarded by the National Examination Board in Occupational Safety and Health (NEBOSH) or have completed Institution of Occupational Safety and Health (IOSH) training providing some specialist health and safety expertise. To strengthen assurance and sustainability, the Health and Safety Training Needs Analysis is being reviewed through the Single Improvement Plan. This will confirm competency requirements, current coverage and any specialist training gaps, informing a prioritised training plan by March 2027. Progress is being monitored through established SIP governance arrangements.

2.9.4 To strengthen the application of moving and handling principles within clinical practice, the Education Moving and Handling Team has commenced a programme of regular ward visits to provide advice, guidance and support to clinical teams. These visits enable direct observation of practice, review of equipment utilisation and engagement with frontline staff to identify opportunities for improvement. Following agreement by the Health and Safety Governance Group, targeted visits will be prioritised in areas with higher levels of musculoskeletal-related sickness absence, enabling focused support, assessment of local practice and the delivery of ward-based training where required.

2.9.5 Display Screen Equipment (DSE) compliance remains a key area of focus for the Health and Safety Governance Group, with a programme of work underway to establish an accurate baseline of DSE users. This is expected to be concluded in October 2026 and is required to determine how many DSE assessors are needed across divisions and to support targeted training of assessors. The Associate Director of Risk and Assurance is working with the Education Team to improve monthly reporting on DSE user numbers and assessor requirements, with progress monitored through the health and safety workstream within the Single Improvement Plan, SIP Patients Board and HSGG. Given the link to staff wellbeing, musculoskeletal health and hybrid working arrangements, discussions are underway to report DSE metrics within the People and Partnerships Committee.

2.9 Improvement Priorities

2.9.1 Whilst significant progress has been made in strengthening health and safety governance arrangements and improving visibility of statutory compliance across the Trust, a substantial programme of work remains to further enhance assurance, oversight and organisational learning. The scale and complexity of the remaining work should not be underestimated, as many priorities relate to longstanding estate, infrastructure, workforce and operational challenges that will require sustained improvement rather than immediate resolution. Continued focus will therefore be required to embed sustainable improvements and support delivery of the Trust's health and safety objectives.

2.9.1 Key priorities for the Health and Safety Governance Group and Health and Safety Team between now and March 2027 include:

- Development of a suite of health and safety key performance indicators and introduction of an integrated dashboard, bringing together multiple sources of intelligence to strengthen oversight, trend analysis and organisational assurance.
- Implementation of a Trust-wide programme of health and safety risk assessments and audits to improve compliance monitoring, identify areas of concern and support proactive risk management.
- Targeted review and reduction of longstanding risks aligned to the Health and Safety Governance Group, with particular focus on high-scoring risks and barriers to risk reduction.

- Strengthening monitoring, tracking and reporting of fire action plans, with the proposed approach due to return to HSGG in November 2026.
- Improvement of the Display Screen Equipment (DSE) assessment process, including strengthening assessment completion rates, documentation, action tracking and assurance arrangements to support compliance with statutory requirements and improve staff wellbeing.
- Review of the Health and Safety Training Needs Analysis to clarify mandatory and specialist training requirements and support sustained compliance above 90% by March 2027.

2.9.2 These priorities will support the continued development of a proactive health and safety culture, strengthen organisational assurance and contribute to the reduction of health and safety risks across the Trust.

3 Conclusion

3.1 The Trust has made significant progress in strengthening its health and safety governance arrangements since November 2025, including substantial progress in response to the Mersey Internal Audit Agency Health and Safety Governance review. Evidence has been submitted to MIAA to support closure of the outstanding recommendation; however, formal closure remains subject to MIAA review and confirmation. The Trust has enhanced oversight through the Health and Safety Governance Group, improved intelligence reporting and developed a more resilient Health and Safety Team structure. The Trust continues to monitor and manage compliance across a number of statutory and regulatory areas and has strengthened arrangements to identify, escalate and respond to health and safety risks.

3.1 Notwithstanding this progress, challenges remain in relation to ageing estate infrastructure, statutory compliance gaps in specific engineering disciplines, workforce resilience, longstanding risks and recurring health and safety themes identified through incident reporting, audits and external inspections. The implementation of the Estates and Facilities Statutory Compliance Tracker, targeted risk reviews for longstanding risks, enhanced audit activity, strengthened performance reporting and focused improvement initiatives will support the continued reduction of risk and improvement of health and safety performance across the organisation.

3.2 The establishment of the full Health and Safety Team by December 2026 will be an important enabler in moving from strengthened governance oversight to sustained delivery, assurance testing and proactive improvement. However, the Board should recognise that the breadth and complexity of the issues described in this report mean that improvement will require continued prioritisation, sustained organisational focus and realistic delivery timescales.

3.3 The Health and Safety Governance Group will continue to oversee delivery of the identified priorities and provide assurance to the Safety and Quality Committee and Trust Board on progress, emerging risks and organisational learning.

3.4 Stabilising the estates workforce function following the transfer to OneLSC is a critical component of effective delivery of the improvements required and the new high risk that relates to estates workforce requires ongoing executive focus through the partnership arrangements in place to work with OneLSC to mitigate the risks being identified.

4. Financial implications

4.1 Residual risks linked to ageing infrastructure, including fire dampers, water safety systems and asbestos encapsulation, and security enhancements will require continued capital investment, which continues to be flexible according to the risks that present within the estate and is overseen through the capital investment group and the Finance and Performance committee.

4.2 A fully costed three-year prioritised estates plan has been developed and shared with NHS England to support consideration of funding requirements; however, confirmation of a long-term funding plan remains outstanding.

5. Legal implications

5.1 The Health and Safety at Work Act 1974 imposes duties on employers to protect the 'Health, Safety and Welfare' of all their employees, as well as others on their premises, including contractors, visitors and the public.

6. Risks

6.1 There are several health and safety risks on the Trust's Risk Register which may lead to non-compliance with legislation and risks to the health, safety and welfare of employees, as well as others on the Trust's premises. These risks arise from a variety of factors.

6.2 All risks are managed in accordance with the Trust's Risk Management Policy RMS-01 and reported and managed through divisional and corporate meetings. However, due to the ageing estate and ongoing financial challenges, it is difficult to eliminate all health and safety risks in their totality.

7. Impact on stakeholders

7.1 The Health and Safety at Work Act 1974 was introduced to apply broad duties and best practice in relation to the health and safety of an organisation's workforce. This includes a duty of care for employees, casual workers, self-employed workers, clients, visitors and the general public. Robust health and safety governance will support the Trust to deliver its regulatory duties in line with the Health and Safety at Work Act 1974.

8. Recommendations

The Board of Directors is asked to:

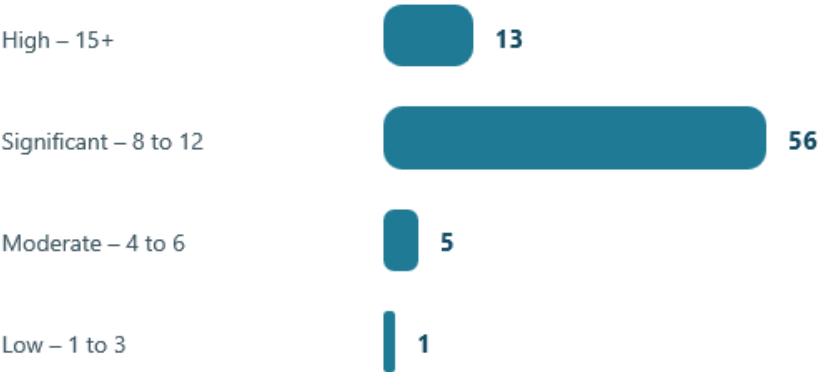
- I. Receive assurance on the progress made to strengthen health and safety governance arrangements, noting that the report has been scrutinised at Safety and Quality Committee and that further work remains required in relation to statutory compliance, estates-related risks and local risk assessment oversight.

Operational Risk Profile – At a Glance

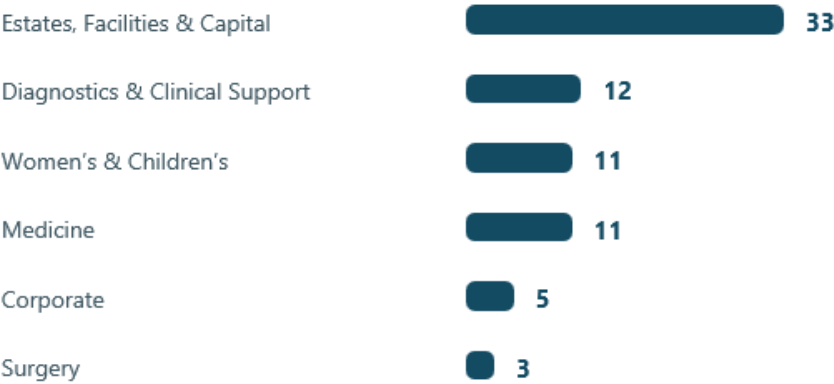
75 active risks aligned to the Health & Safety Governance Group



BY SEVERITY



BY DIVISION



Ageing estate & infrastructure

~30 risks

Electrical supply, water systems, heating, ventilation, lifts, windows, roofs, roads and drains running beyond their design life.

Environment & temperature control

~10 risks

Wards, neonatal, maternity, endoscopy and dialysis areas that cannot be kept at a safe, stable temperature.

Statutory safety compliance

~12 risks

Fire, asbestos, water hygiene, medical gases, ionising radiation, formalin exposure and DSE obligations.

Patient safety in the environment

~8 risks

Ligature points, falls, exit block, call bell and alarm systems, and non-compliant cots and beds.

Violence, aggression & security

~5 risks

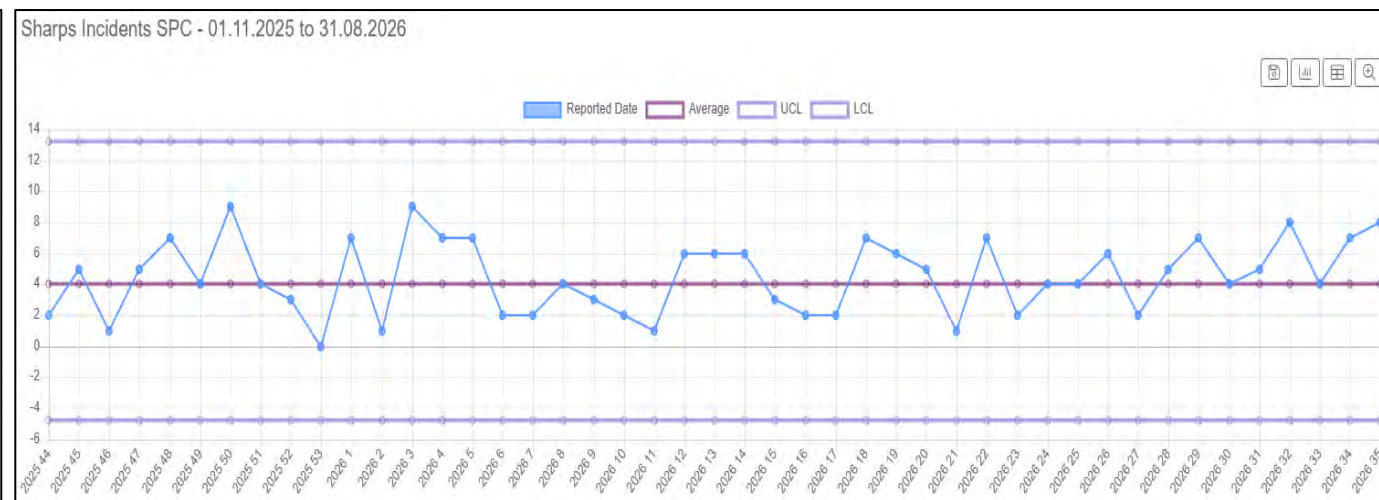
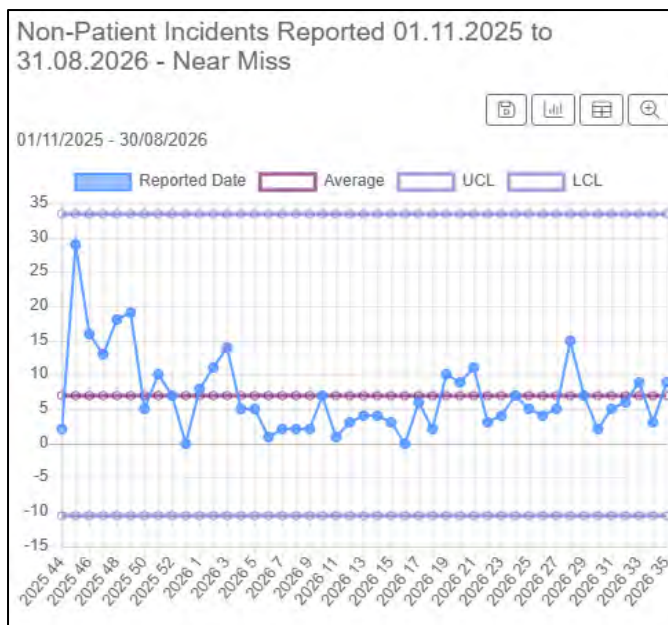
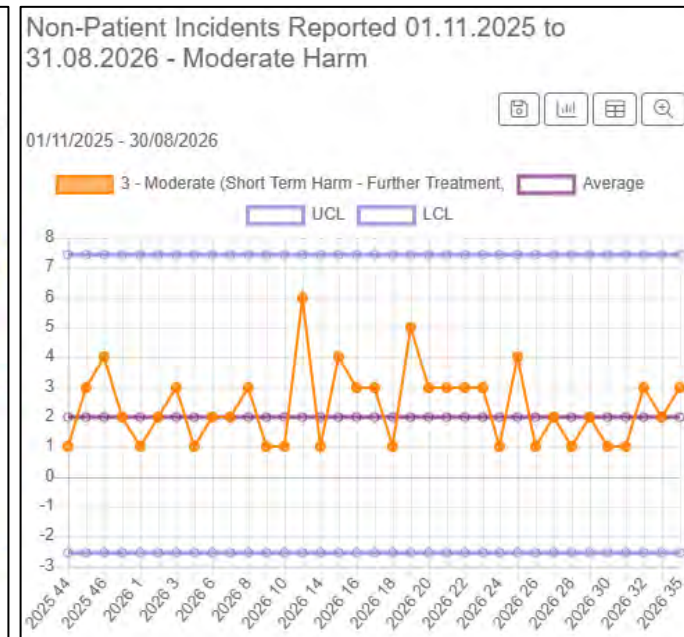
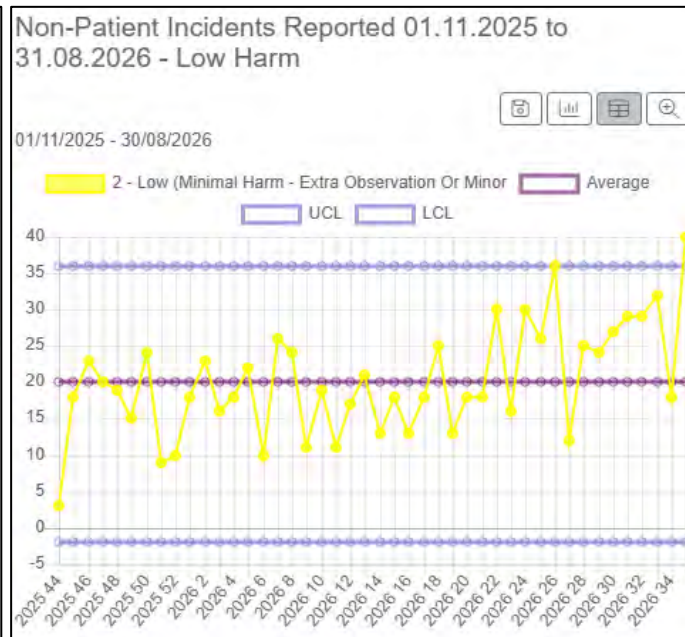
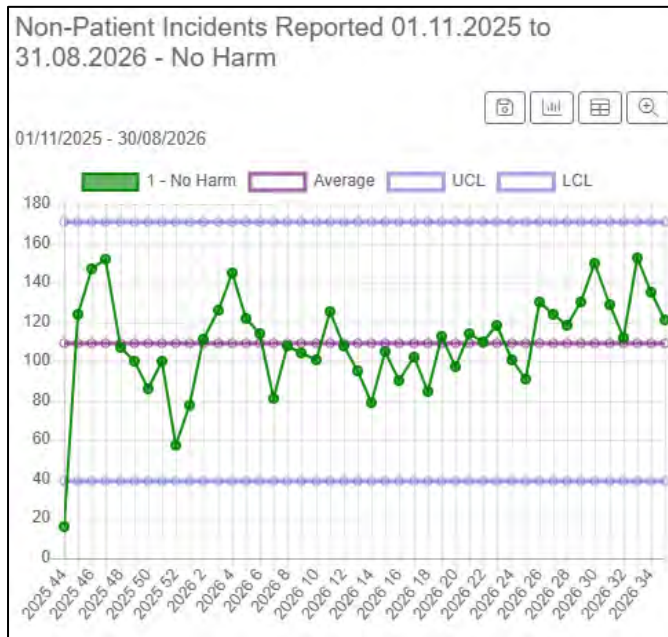
Assaults on staff, abduction and absconsion risk on children's wards, and departments that cannot be locked.

Food, cleaning & decontamination

~7 risks

Patient kitchens, catering services, trust-wide cleaning standards and sterile services workflow.

Appendix Two – Non-Patient Incident Profile 1 November 2025 to 31 August 2026



Appendix Two provides the supporting non-patient incident profile for the reporting period, with the narrative in section 2.6 summarising the key themes, learning and actions being progressed through established governance routes

Appendix Three – Summary of External Inspections, Reviews and Accreditation Visits 1 November 2025 to 31 August 2026

Date of Visit	Type	Name of Visiting Agency/ Organisation	Title	Division	Report Received	Action plan status	Visit status
17.11.2025	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Medicine - CDH	Yes	Completed	Closed
27.11.2025	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Surgery - RPH	Yes	Completed	Closed
08.12.2025	Accreditation	SGS Limited UK	External ISO 13485 / UKCA Accreditation Audit - HSDU	Division of Estates, Facilities and Capital - CDH	Yes	Completed	Closed
09.12.2025	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Diagnostics & Clinical Support Services - CDH	Yes	Completed	Closed
07.01.2026	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Estates, Facilities & Capital - CDH	Yes	Ongoing	Action plan monitoring ongoing. *
21.01.2026	Accreditation	SGS Limited UK	External ISO Accreditation Audit – Medical Devices	Division of Estates, Facilities and Capital – Trust wide	Yes	Completed	Closed
14.04.2026	Inspection	Griffith and Armour	Trust Annual Insurers Inspection	Division of Estates, Facilities & Capital - CDH	Yes	Completed	Closed
24.04.2026	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Surgery	Yes	Ongoing	Action plan monitoring ongoing. *
24.04.2026	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Women and Children	Yes	Completed	Closed
24.04.2026	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Estates, Facilities & Capital - CDH	Yes	Ongoing	Action plan monitoring ongoing. *
26.05.2026	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Surgery	Yes	Ongoing	Action plan monitoring ongoing. *
26.05.2026	Regulatory Inspection	Lancashire Fire & Rescue Service	Fire Safety Visit	Division of Surgery	Yes	Ongoing	Action plan monitoring ongoing. *
11.06.2026	Regulatory Inspection	Environmental Health Agency	Food safety inspection	Division of Estates, Facilities and Capital - RPH	Yes	Not applicable	Closed
12.06.2026	Regulatory Inspection	Health and Safety Executive	IRR (17) Inspection	Corporate Division – Trust wide	Yes	Completed	Closed
19.08.2026	Regulatory Inspection	Health and Safety Executive	Site Inspection following RIDDOR report – CL2 laboratory incident.	Division of Diagnostics & Clinical Support Services - CDH	Yes	In draft	Action plan monitoring ongoing. Due for submission Feb 27.

*For fire safety visits where action plan monitoring remains ongoing, work is underway to strengthen the monitoring, tracking and reporting of fire action plans. The proposed approach will be brought back to the Health and Safety Governance Group in November 2026.

Appendix 4 – Health and Safety Bulletin

Learning and preventative messages are also communicated through targeted Health & Safety Bulletins. The December 2025 bulletin provided staff with practical guidance on clinical waste segregation, prevention and management of sharps incidents, appropriate use of FM First and Incident Management Reporting System for estates issues and safety incidents, and safe use of bariatric equipment for patient transfers. The bulletin also signposts staff to relevant policies, reporting routes and training resources.



HEALTH & SAFETY BULLETIN

Welcome to the Health & Safety Bulletin. As part of our ongoing commitment to creating a safe and supportive working environment across our Trust, this bulletin provides key updates, reminders, and insights to help you stay informed and proactive about health and safety matters.



"Whether you're on the frontline, in support services, or working remotely, your wellbeing and safety are paramount."

In This Issue We Focus On:

 Clinical Waste Segregation Concerns: This is a summary of current clinical waste concerns, why they matter, and links to posters, contacts, and further help. Page 2	 Managing Sharps Incidents And Risk Assessments A spotlight bulletin on reducing injuries and promoting best practices when working with sharps. Pages 3-4	 Estates Issues vs Incidents: What Gets Reported Where? This bulletin explains how to choose the correct reporting route for estates issues and incidents, helping improve safety and resolution times. Page 5	 Safe Use Of Bariatric Equipment For Patient Transfers Guidance on safe patient handling, equipment use, and staff wellbeing. Pages 6 - 8
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A link to the full bulletin is included here: [Health and Safety Bulletin](#)

12.1A EPRR CORE STANDARDS ANNUAL ASSURANCE

● Decision Item

REFERENCES

Only PDFs are attached



12.1a EPRR Core Standards Annual Assurance Ancillary Board Pt I Oct 2026.pdf

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

Acute Providers

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	1	1	0
Training and exercising	4	2	2	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	10	2	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	52	10	0

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

	Core standards	Interoperable capabilities
Fully compliant	62	#REF!
Substantially compliant	55	#REF!
Partially compliant	48	#REF!
Non compliant		

Ref	Domain	Standard name	Standard Detail	Supporting information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Domain 1 - Governance									
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	The Chief Operating Officer is the Trust's appointed Accountable Emergency Officer (AEO) Katie Foster-Greenwood, with the Deputy Chief Operating Officer serving as their delegate when necessary. The Executive Team Portfolio includes EPRR and Business Continuity under the Chief Operating Officer's responsibilities. The EPRR Policy outlines the specific duties of the AEO. EPRR Policy	Fully compliant			
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust has an EPRR Policy that designates the Chief Operating Officer as the Accountable Emergency Officer, responsible for: - Ensuring the Trust has a designated Emergency Planning Officer (head of EPRR and EPRR Officer) in accordance with good practice. - Providing the Emergency Planning Officer (Head of EPRR and EPRR Officer) with the necessary resources, funds, and ensuring all staff are appropriately trained for their roles, with access to an EPRR exercise and training program. - Collaborating with the Emergency Planning Officer (Head of EPRR and EPRR Officer) to develop and maintain adequate and appropriate Emergency Preparedness and Business Continuity Management arrangements, including proper procedures for managing emergency incidents requiring Trust-level command and control. The EPRR Policy is available via the Trust intranet and Heritage document library. The EPRR Policy was last reviewed in June 2026. EPRR Policy	Fully compliant			
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	An EPRR annual summary report, including a statement of compliance and audit, is provided to the Trust Board in the form of the NHSE EPRR Annual Self-Assessment assurance documents and is available in the Board minutes. These reports include updates on training and exercises undertaken in the Trust, summaries of any business continuity, critical, or major incidents experienced, and any lessons identified, if applicable. The Trust's compliance status in relation to the latest NHSE EPRR assurance process is also presented to the Board for oversight and approval. The Head of EPRR is responsible for these board reports. The most recent report was presented to the Board in October 2026. EPRR Board Report. Annual Board Report. Board of Directors Meeting	Fully compliant			
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual EPRR work program aligned with current guidance, best practices, and informed by the NHSE EPRR core standards. The EPRR Committee regularly reviews and reports on the work program, especially in light of identified lessons and risks. This reporting process is detailed in the EPRR Policy. EPRR Workplan & EPRR Policy.	Fully compliant			
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy identifies the current EPRR resource, roles and responsibilities required to deliver the EPRR function, including the structure of the EPRR Team. The Trust has now recruited a Band 6 EPRR Officer, improving the capacity of the EPRR function and supporting delivery of the Trust's EPRR work programme. Whilst the function is fully operational, it continues to be supported by the Capacity Management admin team to provide admin resilience and support. The Trust will continue to review the staffing structure and resource requirements to ensure the EPRR function remains appropriately resourced to meet current and future demands. In addition, the Trust has established internal governance arrangements and organisational structure charts to support the delivery of the EPRR function. EPRR Policy. Structure Chart.	Fully compliant			
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The Trust has clearly defined processes for capturing lessons from incidents and exercises. These are reviewed by the EPRR Committee to inform the future development of the Trust's EPRR arrangements. Lessons identified from live incidents or exercises are shared both internally and externally through incident/exercise reports. In accordance with Core Standard 3, any relevant reports are shared annually with the Board. EPRR Policy. Exercise Action Tracker. Plan Action Tracker.	Fully compliant			
Domain 2 - Duty to risk assess									
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are documented in the Trust's risk register (Datix) and are regularly reviewed by the Head of EPRR. Additionally, these risks are reviewed by the EPRR Committee. Risks on the corporate risk register are reviewed monthly or quarterly as appropriate by the Risk Management Group. EPRR Risk Register EPRR Policy	Fully compliant			
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust employs a robust method for reporting, monitoring, and escalating risks using the Ulysses system. The Head of EPRR reviews risks as required, and the EPRR Committee conducts quarterly reviews. EPRR risk management is also referenced in the EPRR Policy. EPRR Risk Register. EPRR Policy. Trust Risk Management Policy.	Fully compliant			
Domain 3 - Duty to maintain Plans									
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Plans and arrangements have been developed in collaboration with relevant stakeholders, including emergency services and health partners, aimed at enhancing joint working arrangements and ensuring comprehensive consideration of the entire patient pathway. Updates to plans involve collaboration with surrounding Trusts, ICB, local Police, Fire, and Ambulance services where appropriate. External stakeholders were actively engaged in the validation of our CBRNe/HazMat plan. Any adjustments resulting from these consultations, or exercises are captured in the Amendment History tracker within each respective plan. Plan Action Tracker. Amendment History/Consultation on Plans. EPRR Policy Section 5.4.	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has established robust arrangements to define and respond to Critical and Major incidents in accordance with the EPRR Framework. These arrangements are as follows: The Major Incident Response Plan has been fully reviewed and updated within the last year to ensure alignment with the latest national guidance and incorporating feedback from exercises, to enhance preparedness and response capabilities. The updated Major Incident Response Plan has been officially signed off by the appropriate governance bodies within the Trust, ensuring that it has the necessary approval and support at the highest levels. The Major Incident Response Plan was used during a live exercise in June 2025. This exercise tested the effectiveness of the plan and the preparedness of the response staff. All colleagues in attendance from Operational, Tactical and Strategic used the Major Incident Response Plan to ensure response staff were well-prepared to execute the plan during actual incidents and ensured that those responsible for implementing the plan are fully aware of their roles and responsibilities during an incident. OPEL levels are monitored four times a day to assess pressures and capacity within the trust. This frequent monitoring allows for timely and appropriate responses to emerging pressures. Local Business Continuity Plans are in place and can be activated if required to maintain essential services during disruptions. These comprehensive arrangements ensure that the organisation is well-prepared to respond to critical and major incidents, maintaining continuity of care and ensuring patient safety. The recovery arrangements within the Major Incident Response Plan have also been enhanced, with an expanded recovery section and the introduction of dedicated Recovery Action Cards to support a structured transition from response to recovery and the restoration of normal services. Major Incident Response Plan.	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.			
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has established effective arrangements to respond to adverse weather events in accordance with current guidance and legislation. These arrangements are outlined in the trust's comprehensive Adverse Weather & Health Plan, which includes provisions for both hot and cold weather planning and response. The plan was reviewed and updated following an Amber Heat Health Alert in June 2026. Outside of responses, annual reviews are also conducted, ensuring that the plan remains current and aligns with the latest guidance from the UK Health Security Agency (UK HSA) and best practices. Adverse Weather & Health Plan.	Fully compliant			
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppp/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	The Trust has established comprehensive arrangements to respond to infectious disease outbreaks, including a range of diseases and High Consequence Infectious Diseases (HCIDs). The trust has developed a variety of plans and policies to address different infectious agents, ensuring a robust response framework. Specific procedures are in place for the management of Severe Acute Respiratory Infections (SARIS), such as Avian Influenza, MERS-CoV, and SARS. There are also dedicated procedures for managing patients suspected of or infected with Viral Haemorrhagic Fevers (VHFs), including Ebola. All plans and policies are readily accessible to staff via the trust intranet, ensuring that the necessary information and guidance are available when needed. In April 2026, the Trust undertook a HCID tabletop exercise to validate these arrangements, followed by a live HCID response later that day. Debriefs were undertaken following both the exercise and the live response, with lessons identified captured, actioned and monitored through to completion via the Trust's EPRR governance arrangements. These arrangements ensure that the trust is well-prepared to respond effectively to a wide range of infectious disease outbreaks, safeguarding both staff and patients. Procedure for Management of Patients suspected of having or infected with VHF Procedure for Management of Severe Acute Respiratory Infections Outbreak Procedure Isolation Procedure	Fully compliant			
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a comprehensive Pandemic Plan to support the response to new and emerging pandemic threats. The Plan has been comprehensively reviewed and updated in line with the Department of Health and Social Care's Pandemic Preparedness Strategy: building our capabilities (March 2026), together with current NHS England guidance and lessons identified from recent national learning. The updated Plan is scheduled to be validated through a tabletop exercise during the 2026/2027 financial year as part of the Trust's EPRR exercise programme. Pandemic Plan.	Fully compliant			
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	In line with current guidance and legislation, the organisation has established arrangements to support an incident requiring Countermeasures or Mass Countermeasures deployment. This plan has previously undergone consultation both internally and externally. The Pharmacy Department has a proven track record in incident response, including holding regional stocks of Tamiflu and distributing them as needed during flu outbreaks, responding to Covid 19 vaccine rollout and in response to the MPox outbreak. These measures ensure the Trust is well-prepared to support such deployments effectively. The Countermeasures plan was validated during Exercise Hibbert and the Strategic Commander training in September 2024 and will again be exercised alongside the Pandemic Plan during a tabletop exercise in the 2026/2027 financial year. Countermeasures Plan.	Fully compliant			
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Trust has robust arrangements in place to respond effectively to incidents involving mass casualties. The Major Incident Response Plan was fully reviewed and updated within the last year to ensure alignment with the latest national guidance. It also incorporated feedback from Exercise Arkwright, a mass casualty-focused command and control exercise held in June 2025, further enhancing the Trust's preparedness and response capabilities. The current Major Incident Response Plan has been formally approved by the appropriate governance bodies within the Trust. An Trust decant plan is in place to be activated should the ED become overwhelmed during a mass casualty incident. This is supported by established escalation and temporary patient placement procedures. Additionally, the ED has robust processes for safe patient identification, using both the internal Harris Flex system and paper-based records, ensuring effective management of unidentified patients during emergencies. Together, these arrangements demonstrate the Trust's strong preparedness to manage mass casualty incidents efficiently and safely. Major Incident Plan. Business Continuity Plans. Trust Decant Plan.	Fully compliant			
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance and legislation, the organisation has established arrangements for evacuating and sheltering patients, staff, and visitors. The Evacuation and Shelter plan underwent a comprehensive review and consultation process internally and externally in September 2025, aligning with updated national guidance. These measures ensure the organisation is prepared to effectively evacuate and provide shelter to all individuals during emergencies. Evacuation and Shelter Guidance.	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance, legislation and regulatory requirements, the Trust has established arrangements to control access and egress for patients, staff and visitors during incidents affecting its premises and key assets. The Trust maintains an overarching Lockdown/Controlled Access Plan, overseen by the Estates and Facilities Division's Security Management Specialist. The Plan is regularly reviewed and exercised to ensure it remains effective and fit for purpose. In May 2026, the Trust implemented its lockdown procedures in response to malicious calls received by the organisation. A structured debrief was undertaken following the incident, with lessons identified being incorporated into future planning and ongoing improvements to the Lockdown/Controlled Access Plan and wider assurance arrangement. The ICB is satisfied that the Trust meets the requirements of this Core Standard. However, the May 2026 activation highlighted that some areas of the Trust estate remain reliant on manual lockdown arrangements, requiring Security colleagues, supported by Portering colleagues where necessary, to physically secure identified doors and access points. Whilst the current arrangements enable the Trust to implement lockdown, this reliance on manual intervention can affect the speed and efficiency of securing the site and requires staff to physically attend access points during an incident, potentially increasing their exposure to risk. There is also a resilience dependency on the continued availability of sufficient Security and supporting resources. Should this resource be reduced or otherwise compromised during an incident, the Trust's ability to achieve full lockdown could be affected. Further investment in electronic access control and lockdown capability would therefore improve the speed, efficiency, safety and resilience of the Trust's existing arrangements and reduce reliance on manual intervention. Controlled Access/Lockdown Plan. Lockdown Debrief Report.	Partially compliant	Undertake a review of current electronic and manual lockdown arrangements across the Trust estate to identify areas reliant on manual intervention and assess opportunities to increase electronic access control capability. Findings to inform a prioritised, risk-based programme of improvements and associated investment requirements, with consideration given to staff safety, speed of lockdown activation and resilience where Security resources may be reduced or compromised.	EPRR Committee/ Security/ Estates and Facilities Governance	31.03.2027
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance and legislation, the Trust has established arrangements to effectively respond to and manage "protected individuals," including Very Important Persons (VIPs), high-profile patients, and visitors to the site. The trust operates under an overarching Communications Incident Response plan specifically designed for this purpose, overseen by the Communications Team. Additionally, the Security Manager ensures the implementation of robust processes within the trust's security team. These processes are activated upon notification of the presence of a high-profile patient or during high-profile events in the vicinity. Responsibility for managing such incidents is clearly outlined within the organisation's EPRR Policy and Major Incident Plans, ensuring a coordinated and secure environment for all individuals of importance within the trust's premises. Communications Incident Response Plan. Prisoners in Hospital Procedure.	Fully compliant			
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multi-agency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance • in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has actively participated in and comprehends its role within multi-agency arrangements for handling excess deaths and mass fatalities, including mortuary management for rising tide and sudden onset events. The Trust has implemented a robust mortuary surge management plan designed to expand capacity during periods of heightened demand. The Mortuary team is thoroughly acquainted with both internal and external processes and arrangements. They continuously monitor onsite capacity and escalate as necessary. Effective communication is maintained between the EPRR Team and the Mortuary Team, ensuring all are prepared to raise any concerns promptly. This coordinated approach ensures the organisation is well-prepared to manage and respond to scenarios involving excess deaths and mass fatalities, contributing effectively within the broader multi-agency framework. Mortuary Surge Management Guideline.	Fully compliant			
Domain 4 - Command and control									
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The Trust has robust structures in place to ensure 24/7 receipt and escalation of incident notifications, both internal and external. Notifications can be escalated to executive level when required. The EPRR Policy defines the roles, responsibilities, and processes within the Command and Control structure. Expectations for on-call personnel are clearly outlined in the Policy and further supported by an on-call handbook and SOP, which detail the 24-hour alerting process for managers and key personnel. The on-call rota is accessible via the Trust intranet, and Switchboard can connect staff to the on-call manager at any time. A dedicated incident reporting line is in place within Switchboard, supported by a cascade process to ensure timely communication. The on-call alerting process is tested at least every six months, with additional real-world validation during events and exercises. Processes are regularly reviewed to ensure continued effectiveness and resilience EPRR Policy. Exec On Call - Strategic Commander Guidance Tactical & Strategic Commander SOP.	Fully compliant			
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The Trust maintains a 24/7 Tactical and Strategic Commander on-call rota to manage escalations, make decisions and coordinate the Trust response. On-call commanders are expected to undertake NHS England EPRR PHC training aligned with the National Minimum Occupational Standards and the Trust's Training Needs Analysis (TNA). Currently, 41% of on-call personnel have completed the NHS England EPRR PHC training, with a programme of training in place to increase compliance across the on-call cohort. Commanders follow defined decision-making processes set out in the EPRR Policy and are supported by role-specific guidance, skills-based training and regular exercises simulating escalation scenarios. Familiarity with the Joint Emergency Services Interoperability Principles (JESIP) and use of the Joint Decision Model (JDM) underpin their approach. On-call colleagues are clear on consultation and communication protocols, ensuring a collaborative and coordinated response. Maintaining accurate logbooks and decision records is a core expectation. Training compliance is monitored through the Trust's EPRR Training Needs Analysis (TNA), with refresher training delivered in line with identified requirements to maintain and strengthen command capability. EPRR Policy. Training Needs Analysis. Training Records. On-Call Rota. Exec On Call - Strategic Commander Guidance Tactical & Strategic Commander SOP.	Partially compliant	The Trust has an established EPRR Training Needs Analysis (TNA), training programme and central training record that support the development of Tactical and Strategic Commanders. However, compliance with all elements of the training requirements identified within the TNA is not yet fully achieved across all cohorts, resulting in a partial compliance assessment.	EPRR Committee and divisional compliance reporting	31.12.2026
Domain 5 - Training and exercising									
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The Trust delivers and facilitates EPRR training in line with a comprehensive Training Needs Analysis (TNA) to ensure staff remain competent in their emergency preparedness, resilience and response roles. Training requirements are detailed within the EPRR Policy and supported by the EPRR Training and Exercising Programme. The TNA clearly defines the training requirements for on-call personnel, and the wider EPRR team. Training is delivered through a combination of locally facilitated sessions, internal and external training opportunities, nationally available e-learning packages and participation in exercises, with colleagues directed to the learning appropriate to their role. A central training record is maintained by the EPRR Team to monitor attendance, compliance and participation in training and exercises. Whilst the Trust has established a comprehensive training framework, compliance with mandatory EPRR training for key on-call roles is not yet at the desired level. A programme of training and refresher sessions is in place to improve compliance with the requirements set out within the Training Needs Analysis, supported by ongoing monitoring through the Trust's EPRR governance arrangements. The Trust is also progressing the implementation of its EPRR training programme within the Blended Learning system. This will further strengthen compliance monitoring and reporting, provide staff with more accessible and flexible learning opportunities, and support improved completion rates across key EPRR roles. EPRR Policy. Training Needs Analysis. Training Records. Training & Exercising Guidance.	Partially compliant	The Trust has an established EPRR Training Needs Analysis (TNA), training programme and central training record that support the development of Tactical and Strategic Commanders. However, compliance with all elements of the training requirements identified within the TNA is not yet fully achieved across all cohorts, resulting in a partial compliance assessment.	EPRR Committee and divisional compliance reporting	31.12.2026

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	The Trust maintains an exercising and testing programme that meets national requirements and current guidance, ensuring response arrangements are rigorously tested without compromising the safety of participants or patients. Our approach exceeds the minimum standard, with a range of exercises conducted across various scenarios since the last reporting period: - 3 communication exercises - 2 tabletop exercises - Live exercises including an ED lockdown at RPH, decontamination testing at RPH - 7 business continuity exercises Exercises involve colleagues from a wide range of clinical and corporate services to ensure a coordinated, whole-organisation response to incidents. During the last reporting period, 45% of Tactical and Strategic Commanders participated in one or more exercises, providing valuable opportunities to develop and validate command capability. Lessons identified from all exercises and training events are systematically captured, informing plan updates and enhancing future preparedness. All exercises are delivered with strict safety controls to ensure no undue risk to participants or patients. Union representatives have been invited to participate in exercises and training sessions. Exercise Schedule. Exercise Reports. Exercise Action Tracker. Incident Debrief Reports.	Fully compliant			
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	The EPRR Team maintains a central record of training and exercise attendance to support individuals in key response roles receiving the appropriate training for their responsibilities in line with the National Minimum Occupational Standards (NMOS). A comprehensive Training Needs Analysis (TNA) identifies the training requirements for on-call staff and other key responders, ensuring that training is proportionate to their role. Training requirements and compliance are regularly reviewed against the TNA, with the central training record used to monitor completion and identify where further training is required. The Trust continues to offer and deliver training and refresher sessions to improve compliance across key response roles. The Trust is also progressing the implementation of its EPRR training programme within the Blended Learning system. This will further strengthen compliance monitoring and reporting, while providing staff with more accessible and flexible training opportunities. Training Needs Analysis. Training Records.	Partially compliant	The Trust has an established EPRR Training Needs Analysis (TNA), training programme and central training record that support the development of Tactical and Strategic Commanders. However, compliance with all elements of the training requirements identified within the TNA is not yet fully achieved across all cohorts, resulting in a partial compliance assessment. During 2026, the Trust has implemented a revised 24/7 command and control model, introducing Trust Operational Officers as Tactical Commanders and undertaking a review and refresh of the Strategic Commander arrangements. As part of this transition, the Trust is relaunching its EPRR training package to ensure all Tactical and Strategic Commanders receive the training, exercising and development opportunities required for their roles in accordance with the National Minimum Occupational Standards and local Training Needs Analysis. In parallel, the Trust is migrating EPRR training records and learning packages into the corporate Blended Learning platform. This will provide enhanced compliance monitoring, automated training reminders, improved reporting functionality and greater accessibility of learning materials. The revised approach will strengthen oversight of training compliance, support personal development portfolios for key responders and provide greater assurance that commanders and responders maintain competency for their emergency response roles.	EPRR Committee and divisional compliance reporting	31.12.2026
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	General awareness training, covering the Trusts role and staff responsibilities in an incident, is accessible to all staff. This training includes basic understanding of different declarations, specific actions needed, and plan locations. Mandatory EPRR awareness training is included in the biennial Fire Safety training. On-call staff are informed of their incident roles and plan locations. Incident plans are accessible on the intranet, SharePoint and as hard copies in ICCs. Business Continuity plans are available both on the intranet and locally in hard copy within the Tactical ICC. Action Cards for response roles are in hard copy within ICCs and electronically on the intranet and SharePoint. All Commanders have access to NHSE Principles for Health Command training and various additional training and exercising opportunities take place as required (detailed in Core Standard 23). Exercise & Training Attendance Records. Fire Safety & EPRR Training Figures. Board Report.	Fully compliant			
Domain 6 - Response									
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The Trust has robust arrangements in place to coordinate incident response in line with national guidance. Our Incident Coordination Centres (ICCs) are designed to be flexible and scalable, supporting a range of incident types and operating hours as required. ICCs are established at both main sites, with an identified fallback location to ensure continuity. These operational areas are effectively 'exercised' daily through use and regularly checked by the EPRR team. Equipment is tested routinely and following any significant infrastructure changes to ensure continued functionality and readiness. Documentation to support ICC activation and operation is in place, including the ICC Protocol and the Incident Management Team (IMT) Standard Operating Procedure (SOP). Virtual arrangements are also established to complement physical facilities, enhancing resilience through alternative contingency options. Incident Coordination Centres Protocol. EPRR Policy.	Fully compliant			
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Response documents are available on the intranet, SharePoint, and in hard copy within the ICC. The EPRR Team ensures version control is maintained on these documents. Response staff are aware of where to locate plans. Additionally, processes are in place for retaining documents for required periods. Intranet EPRR Pages. SharePoint/OneDrive Folders. Major Incident Cupboard in ICC.	Fully compliant			
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The Trust has a Business Continuity Incident Response Plan and in addition all critical services within the trust have individual business continuity plans to mitigate against various scenarios, such as loss of premises or electricity. Currently, there are 94 BCPs within trust services, each reviewed regularly or upon activation/key changes, and all detailing action cards and escalation processes. These BCPs are accessible electronically on the intranet, with hard copies available locally and in the Major Incident cupboard in the Tactical Incident Coordination Centre. Business continuity plans are reviewed within their divisions, with the process monitored by the EPRR Team. Concerns are escalated to divisional leads and through the EPRR Committee meeting. A spreadsheet of the BCPs is maintained and manually monitored on a monthly basis by the EPRR Team. Intranet EPRR Pages. SharePoint/OneDrive Folders. Major Incident Cupboard in ICC. Business Continuity Incident Response Plan.	Fully compliant			
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The Trust maintains a bank of trained Loggists available 24/7, with contact details accessible in both the TICC and SICC. In their absence, key response staff are aware of the requirement to maintain personal decision logs in line with the organisation's records management policy, handing over to a trained Loggist as soon as practicable. The Major Incident Plan outlines the process for accessing and deploying Loggists and emphasises the importance of maintaining accurate records. Record retention requirements are also detailed within the Plan. Staff action cards include clear prompts to begin personal logs if a Loggist is not immediately available. Loggists and response staff have participate in training and exercises, helping to build familiarity and strengthen collaboration during incidents. Log books are readily available in the ICC for immediate use. From September 2026, Loggist training will be delivered in-house by the Trust's EPRR Officer, with the first two training sessions already scheduled. This will increase local training capacity and support the ongoing development of the Trusts Loggist capability. Log book in Major Incident Cupboard in ICC. Loggists Details. Major Incident Plan. Training records/TNA. Loggist Training Slides	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SiReps) and briefings during the response to incidents including bespoke or incident dependent formats.	- Documented processes for completing, quality assuring, signing off and submitting SiReps - Evidence of testing and exercising - The organisation has access to the standard SiRep Template	Processes are in place for receiving, completing, authorising, and submitting SiReps. A single point of contact (SPOC) email inbox is monitored daily by the EPRR Team and Trust Operational Officers. The trust ensures effective communication through various meetings and calls: - Daily System Control Centre Call at 10:30 - Daily bed meetings at 09:00, 12:00, 15:00, and 19:00, administered by the Capacity Management Team The SiRep process is clearly documented, regularly rehearsed, and includes quality assurance and executive sign-off before submission. The SPOC manages circulation, follow-up, and timely submission to ensure accuracy and compliance. The Trust utilises the standard SiRep template and has tested these procedures in both exercises and real-time responses. Most recently, the process was successfully applied during the Blood Sciences Industrial Action in June 2026. SiRep Templates. Major Incident Plan. Key clinical staff have access to the Clinical Guidelines for Major Incident and Mass Casualty events either on the Intranet or a hard copy in the Emergency Department.	Fully compliant			
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	EPRR Intranet. LTH EPRR SharePoint/OneDrive. Clinical staff have access to the CBRN incident: Clinical management and health protection Guidance either on the Intranet or a hard copy in the Emergency Department.	Fully compliant			
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	EPRR Intranet. LTH EPRR SharePoint/OneDrive.	Fully compliant			
Domain 7 - Warning and informing									
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	- Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. - Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. - Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. - Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The trust has an overarching Communications Incident Response Plan. The communications team is fully aware of the organisation's incident response plan and the procedures for reporting potential incidents. Staff have been trained in incident terminology to ensure accurate declarations in line with the NHS EPRR Framework. Measures are in place to ensure incidents are appropriately described and declared. Contact details for on-call communications staff are available 24/7 within the ICCs or via Switchboard. A media-trained member of staff is available around the clock to support senior leaders during incidents. The communications team maintains a process for logging incoming requests, tracking responses, and ensuring that all information related to incidents is stored effectively. All email correspondence received via the EPRR route is stored within Outlook folders or the Trust SharePoint folders. Records of all enquiries received by the communications team are meticulously kept to provide evidence if required for an inquiry. Communications Incident Response Plan. Adverse Weather Alert Emails.	Fully compliant			
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	- An incident communications plan has been developed and is available to on call communications staff - The incident communications plan has been tested both in and out of hours - Action cards have been developed for communications roles - A requirement for briefing NHS England regional communications team has been established - The plan has been tested, both in and out of hours as part of an exercise. - Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Trust has an overarching Communications Incident Response Plan that outlines arrangements for communicating with partners and stakeholders during and after an incident. The Communications Team is responsible for maintaining, reviewing, and regularly exercising this plan to ensure it remains effective. Hard copies of the Communications Plan, Major Incident Response Plan, and key contact guidelines are available in the ICC. The Communications Team maintains a spreadsheet logging all inbound media requests and the Trust's responses. They also keep a daily communications log to track media mentions and relevant developments. Communications Incident Response Plan. Major Incident Response Plan.	Fully compliant			
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	- Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications - A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. - A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident - Appropriate channels for communicating with members of the public that can be used 24/7 if required - Identified sites within the organisation for displaying of important public information (such as main points of access) - Have in place a means of communicating with patients who have appointments booked or are receiving treatment. - Have in place a plan to communicate with inpatients and their families or care givers. - The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The Trust has developed a Communications Incident Response plan to ensure effective communication with stakeholders before, during, and after incidents. This includes patients, staff, partner organisations, stakeholders, and the public. Key elements of the plan include: Established channels to ensure timely communication with staff during incidents, including out-of-hours. Access to critical contacts in partner organisations to warn and inform them about incidents and ensure consistent messaging across different levels. Processes are in place to brief local stakeholders like elected officials and unions during incidents. 24/7 channels are available to communicate effectively with the public. Designated sites within the organisation to display crucial public information during critical times. Plans in place within the Trust to inform patients about appointment changes and to communicate with inpatients and their families during incidents. The Trust publicly acknowledges its preparedness in annual reports, complying with regulatory requirements. The Trust has a trained media spokesperson capable of representing the organisation effectively at all times. Overall, the Communications Incident Response Plan is managed by the Communications Team to maintain readiness for any potential incident. Communications Incident Response Plan. Mobile Messaging in Incident Response.	Fully compliant			
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	- Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media - Develop a pool of media spokespeople able to represent the organisation to the media at all times. - Social Media policy and monitoring in place to identify and track information on social media relating to incidents. - Setting up protocols for using social media to warn and inform - Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust has a Communications Incident Response Plan in place to support timely and structured communication via traditional and social media during incidents. Key components include: - Media Strategy & Spokespeople: A pool of trained media spokespeople is available to ensure accurate and timely communication with the media. - Social Media Policy & Monitoring: The Communications Team oversees a robust policy for monitoring and engaging on social media, enabling proactive responses to emerging issues. - Social Media Protocols: Clear protocols guide the use of social media to warn and inform the public and stakeholders during incidents, ensuring consistent and appropriate messaging. The plan is maintained by the Communications Team and provides structured guidance to ensure effective communication throughout an incident response. The Trust also has a media enquiries policy and procedure - this policy ensures media enquiries are consistently managed within the organisation to protect and enhance the reputation of LTHTr and to ensure patient confidentiality is safeguarded. Communications Incident Response Plan. Media Enquiries Policy and Procedure. Social Media and Social Networking Policy	Fully compliant			
Domain 8 - Cooperation									
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	- Minutes of meetings - Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Our AEO (Chief Operating Officer) serves as the Trust's representative at the LHRP meetings. In the event that the AEO is unavailable, the Deputy Chief Operating Officer or one of the Divisional Directors is delegated to attend on their behalf, with the authority to authorise plans and commit resources for the Trust. A representative from the Trust has been in attendance at each of the LHRP meetings held during this assessment period. EPRR Policy. LHRP Minutes/Attendance Record.	Fully compliant			
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	- Minutes of meetings - A governance agreement is in place if the organisation is represented and feeds back across the system	As a Category 1 responder, the Trust is a member of the Local Resilience Forum (LRF). While formal attendance at LRF meetings and working groups falls under the remit of the Deputy Chief Operating Officer (DCOO), representation is delegated to the Lancashire & South Cumbria ICB. Trust information is shared with the LRF via the ICB, and relevant updates are cascaded back to the Trust's Accountable Emergency Officer (AEO) and EPRR Team by the ICB EPRR team. Further dissemination is carried out as needed. Information is also shared through LRF General Purposes meeting minutes and updates posted on the LRF Teams channel, to which the Head of EPRR has access.	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual aid arrangements are referenced in the Major Incident Plan, enabling us to both access and offer mutual aid as needed. Requests for mutual aid can also be managed through the LSC System Control Centre. Typically, most mutual aid requests currently arrive via the EPRR inbox and are then appropriately cascaded. The acute providers across L&SC have an agreed mutual aid process in place; signed off in June 2025. Major Incident Plan. Mutual Aid Agreement for L&SC. Veolia MOU.	Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.			
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	As a Category 1 responder, the Trust will share data in compliance with the Civil Contingencies Act and the EPRR Framework. We utilise Teams Channels, Email, Internet, and Telephone to share appropriate information externally with access to Resilience Direct also and manage information sharing via command and control internally during incident responses. The EPRR Policy and Major Incident Plan emphasise the importance of adhering to the UK General Data Protection Regulation (UKGDPR) when sharing information. All Freedom of Information (FOI) requests related to EPRR are managed by the FOI team within the Trust. Over the past 12 months, EPRR has handled numerous FOI requests, reflecting our commitment to transparency and compliance, though this process has been time-consuming. EPRR Policy. Major Incident Plan. FOI Policy and Procedure. IG & Information Risk Policy. Information Security Policy & Procedure.	Fully compliant			
Domain 9 - Business Continuity									
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The Trust is committed to undertaking business continuity and maintaining a Business Continuity Management System (BCMS) that aligns with ISO standard 22301. The overarching Business Continuity Policy incorporates the BC policy statement and full BCMS commitment. The EPRR Policy and Major Incident Plans further emphasise the Trust's dedication to developing robust business continuity plans, ensuring services can recover and/or be maintained during disruptions. Each business continuity plan has a designated owner responsible for keeping the plan complete, up to date, and regularly reviewed and exercised. Our BCMS and Business Continuity Plan (BCP) template are aligned with the ISO 22301 standard. EPRR Policy. Major Incident Plan. Business Continuity Policy.	Fully compliant			
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The Trust is committed to maintaining an effective Business Continuity Management System (BCMS) aligned with ISO 22301. This commitment is set out within the Trust's overarching Business Continuity Policy, which provides the framework for the organisation's approach to business continuity management. Since the last reporting period, work has continued to further embed the BCMS across the organisation. This has resulted in increased engagement with the business continuity process and is reflected in improved compliance with Business Continuity Plan reviews, exercising and audit requirements. Business Continuity Policy Risk Management Policy	Fully compliant			
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	The Risk Management Strategy talks through the Board Assurance Framework (BAF) which exists within the Trust with the BAF recording organisational wide risks that include risks identified in relation to the business objectives, corporate objectives and the care quality commission Standards. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors via Committees of the Board. The BAF is presented to the Board of Directors meeting on a bi-monthly basis. The frequency at which a Risk is reviewed is determined by the risk score with higher scoring risks requiring more frequent review. The high risks to the organisation are overseen by Senior Leaders, Committees of the Board and Trust Board. Critical Services and interdependencies are listed in the Business Continuity Policy. Business Impact Analysis and Risk Assessment templates are available in the policy for business continuity plan owners to utilise to inform their business continuity plans. Business Continuity plan owners are expected to review their plans annually. Auditing of the BCP's is undertaken by the EPRR Team and feeds into the EPRR Committee meetings. Business Continuity Policy. Risk Management Policy. Risk Management Strategy.	Fully compliant			
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Local Business Continuity Plans (BCPs) are in place across services, outlining how each will respond to, manage, and recover from disruptions affecting staff, data, premises, suppliers, contractors, and IT infrastructure. Plans are developed in accordance with the Trust Business Continuity Policy and are aligned with ISO 22301 and the NHS Business Continuity Management Toolkit. The Trust requires BCPs to be reviewed by the identified plan owner at least annually, and additionally following significant organisational change, plan activation, exercises or identified learning. A central BCP register is maintained by the EPRR Team, capturing plan ownership, review dates, audit outcomes and exercising status. Review of the register has identified that approximately seven BCPs are currently overdue their required annual review. Whilst the Trust has established business continuity arrangements and the majority of plans remain within their required review cycle, this represents a gap against the Trust's requirement for all BCPs to be reviewed at least annually. BCP owners will be required to complete the outstanding reviews and ensure that plans are subsequently reviewed at least annually in accordance with the Trust Business Continuity Policy. The EPRR Team will continue to maintain central oversight through the BCP register and identify overdue reviews to relevant plan owners. BCP Template Audit Template. BCP Log.	Partially compliant	BCP owners to complete all outstanding annual reviews and ensure that their Business Continuity Plans are reviewed at least annually thereafter, in accordance with the Trust Business Continuity Policy. The EPRR Team will maintain central oversight of review status through the BCP register and highlight overdue plans to the relevant BCP owners. EPRR Committee and divisional assurance routes	31.12.2026	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	The EPRR team leads on delivering tabletop exercises using a range of scenarios to test the robustness of service-level Business Continuity Plans (BCPs). As of the reporting date, seven exercises have been completed since the last time of reporting, with further sessions scheduled. The Trust has a well-established business continuity exercise programme, with regular tabletop exercises undertaken across the organisation to validate Business Continuity Plans (BCPs). Each exercise is followed by a structured debrief to identify lessons and opportunities for improvement. Post-exercise reports are issued to services, setting out actions and recommendations. Progress against these actions is monitored by the EPRR Team and reported through the EPRR Committee, providing assurance that lessons identified are implemented and embedded into future planning. The exercise programme continues to validate the effectiveness of Business Continuity Plans while promoting awareness of business continuity responsibilities across the organisation. Alongside the wider work to embed the Business Continuity Management System (BCMS), this has contributed to improved organisational engagement and increased compliance with Business Continuity Plan reviews, exercising and audit requirements. In accordance with the Trust Business Continuity Policy, individual BCP owners are also responsible for ensuring that their plans are exercised at least annually, and additionally following significant organisational change or where learning indicates that further testing is required. Whilst there is established assurance and supporting evidence for exercises facilitated through the EPRR Team, there is currently a gap in central assurance regarding exercises undertaken independently at service level. The EPRR Team does not currently have consistent oversight or evidence to demonstrate that all BCP owners are exercising their plans annually in accordance with the Trust Business Continuity Policy. The Trust is therefore unable to provide full organisational assurance that the annual exercising requirement is being consistently met across all service-level BCPs. BCP Exercise Reports. Exercise Action Tracker. BC Incident Debrief Report.	Partially compliant	BCP owners to ensure that their Business Continuity Plans are exercised at least annually, in accordance with the Trust Business Continuity Policy, and that appropriate evidence of locally undertaken exercises, including identified learning and actions, is provided to the EPRR Team. The EPRR Team will strengthen central oversight by recording and monitoring exercising status through the BCP register, with gaps in compliance highlighted to BCP owners and reported through the EPRR Committee. EPRR Committee and divisional assurance routes	30.03.2027	

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The Information Technology department has submitted all evidence items for the Data Protection and Security Toolkit for the 2025-26 year. The 2025-26 submission is rated as 'Approaching Standards', representing an improvement from the previous year where standards were not met. An improvement action plan is in place addressing the five areas of assurance required to achieve 'Standards Met'. Whilst this demonstrates positive progress, the Trust has not yet achieved 'Standards Met' and there remains a gap in assurance against the requirements of this Core Standard. The Trust is therefore assessed as Partially Compliant pending completion of the identified actions and confirmation that the required standard has been achieved. Confirmation was provided by L. Magee (Head of Information Governance). Data Protection and Security Toolkit.	Partially compliant	Information Governance Team to progress and complete the existing DSPT improvement action plan, addressing the five identified areas of assurance, with all actions due for completion by July 2027 to support achievement of 'Standards Met'.	Information Governance and Digital Governance	30.06.2027
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	The BCMS is monitored by the EPRR Team and reviewed by the EPRR Committee. Key Performance Indicators (KPIs) used for monitoring are captured within the BCMS. Reports on these KPIs and the outcomes of exercises are included in the annual EPRR board report, ensuring that the board is kept informed of the BCMS status and any necessary corrective actions. BC Policy (including BCMS). Board Report.	Fully compliant			
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The Trust has a process for internal audit as referenced in the BCMS within the BC Policy. An EPRR annual summary report, statement of compliance, and audit are provided to the Trust Board in the form of the NHSE EPRR Annual Self Assessment assurance documents and the EPRR annual board report. The Trust maintains a cycle of business for external audits, which EPRR aligns with, though EPRR has not had an external audit since the last core standards submission. This structured approach ensures that audits are conducted at planned intervals to confirm conformance with the business continuity programme, and outcomes are reported. BC Policy (including BCMS). Board Report. Audit Template.	Fully compliant			
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing • Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Feedback	The Trust has a process to assess the effectiveness of its Business Continuity Management System (BCMS) and implement corrective actions to support continual improvement, as set out within the EPRR Policy and Business Continuity Management Plan. In June/July 2026, the Trust's EPRR arrangements underwent an external audit by MIAA. At the time of reporting, the outcome of the audit is awaited. Post-exercise reports are provided to services, setting out actions and recommendations, which are captured and monitored by the EPRR Team and reported through the EPRR Committee to ensure appropriate oversight and accountability. Plan owners are required to review their Business Continuity Plans at least annually, or sooner where significant organisational or service changes occur, to ensure they remain current and effective. This structured approach ensures that lessons identified, recommendations and improvements are documented, monitored and incorporated into the BCMS to support continual improvement. BC Policy (including BCMS). Post Exercise Reports. Exercise Action Tracker.	Fully compliant			
53	Business Continuity	Assurance of commissioned providers / suppliers BCPS	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The Business Continuity Management System (BCMS) outlines the process for obtaining assurance of the business continuity arrangements of commissioned providers and suppliers, ensuring alignment and interoperability with the Trust's own continuity arrangements. This includes a Provider/Supplier Assurance Framework and supplier audit template to support colleagues in obtaining appropriate assurance. Business continuity assurance is increasingly being sought from locally commissioned providers and suppliers where services are procured directly by the Trust, providing greater assurance that appropriate continuity arrangements are in place for those services on which the organisation is dependent. For nationally procured services and contracts, the Trust has limited oversight of individual supplier business continuity arrangements, as these are managed through the relevant national procurement arrangements. Whilst the Trust is able to seek business continuity assurance from locally procured providers and suppliers, it is not able to obtain the same level of assurance for nationally procured services, as this sits outside the Trust's direct control. BC Policy (including BCMS).	Partially compliant	An initial review will be undertaken to identify current arrangements and agree a risk prioritised approach for identifying critical third-party services, defining responsibilities and obtaining appropriate business continuity assurance. A register of external business continuity arrangements for critical third-party services will be maintained, with evidence of appropriate governance oversight.	EPRR Committee with procurement, contracting and divisional governance	31.03.2027
Domain 10 - CBRN									
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Details of accountability for the Trusts HazMat and CBRN response, including emergency planning, are clearly outlined in the HazMat and CBRN Response Plan. Training and exercise requirements are also detailed within the HazMat and CBRN Response Plan to ensure readiness and proficiency in response protocols. Specific roles for hospital decontamination and their respective action cards are clearly defined within the HazMat and CBRN Response Plan, ensuring clarity and efficiency in emergency response efforts. The Decontamination Equipment Capabilities guideline specifies roles responsible for equipment checks and maintenance. HazMat & CBRN Response Plan. Decontamination Equipment Capabilities Guideline.	Fully compliant			
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	The Trust has implemented a HazMat & CBRN Response plan that comprehensively outlines response arrangements, operational protocols, required competencies, and procedures for managing hazardous waste. This plan includes a dynamic risk assessment process tailored to the presenting casualty, ensuring staff welfare is prioritised throughout and after the incident. The hazardous substance management pathway within the policy addresses the safe handling and disposal of hazardous waste, aligning with regulatory guidelines. The Clinical Business Manager/Speciality Business Manager for the Emergency Department assumes responsibility for conducting risk assessments (RAs) across Trust sites where decontamination may occur. These RAs evaluate potential impacts on staff, estates, and infrastructure, including considerations for access and egress. They also assess the impact of decontamination procedures on critical facilities and services, ensuring continuity of operations during emergencies. This structured approach ensures that Hazmat/CBRN risk assessments are robust, responsive to varying scenarios, and integral to maintaining the safety and functionality of Trust facilities. HazMat & CBRN Response Plan. ED Risk Assessment.	Fully compliant			
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Contact details for the 24-hour on-call consultant from the UK Health Security Agency are included in the HazMat and CBRN Response plan and displayed in the Emergency Department and ICC. This ensures accessibility for key clinical staff needing specialist advice during HazMat/CBRN incidents. Additionally, the plan outlines procedures for accessing other specialist clinical advice as needed, with relevant contact information provided. The plan also references NHS England guidance to further support clinicians in managing patient care effectively during such incidents. The plan also specifies the decision-making process that follows upon receipt of specialist advice. These arrangements ensure that staff are well-informed and prepared to access timely and appropriate specialist advice for ongoing patient treatment. HazMat and CBRN Response Plan. Signage in ED.	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •Command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition	The Trust has a robust HazMat and CBRN Response Plan, supported by the Decontamination Equipment Capabilities Guideline. Both documents are available on the intranet and in hard copy within the Emergency Department. Established procedures enable the activation and deployment of HazMat/CBRN-trained staff and Clinical Decontamination facilities. Predetermined decontamination locations are clearly defined, with separation of clean, decon, and dirty zones to ensure safe patient access and effective cordon control. The plans include protocols for both dry and wet decontamination, with clear decision-making criteria. Staff welfare and decontamination are prioritised, alongside business continuity measures to maintain patient flow via designated clean entry routes. The plans also cover hazardous waste management, the transition from response to recovery, and processes for replenishing PPE/PRPS. Staff training is delivered through the Northern Care Alliance, with in-house refresher sessions and local familiarisation provided by the ED CBRN Link (Senior Sister) and the EPRR Team. This comprehensive approach ensures preparedness and supports swift recovery to normal operations following a HazMat/CBRN incident. HazMat and CBRN Response Plan. Decontamination Equipment Capabilities Guideline. Training Records and TNA.	Fully compliant			
59	Hazmat/CBRN	Decontamination capability availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	The Trust maintains adequate and appropriate decontamination capability to manage self-presenting patients at all times. Trained staff are readily available to operate these facilities, as outlined in the HazMat and CBRN Response Plan, which specifies documented roles for the decontamination team, including the Entry Control/Safety Officer. CBRNe training and staff availability are overseen by the Clinical Educators for ED. All Band 7 ED staff have completed comprehensive CBRNe/HazMat and PRPS training, delivered over two days by the Northern Care Alliance, with transition plans in place for NWAS training. A list of trained staff is available in the ED office, and those on shift each day are clearly recorded on the Band 6 and 7 rotas. In addition, trained staff are aware that they must identify themselves during an incident. To support escalation, a major incident WhatsApp group has been established for ED staff, enabling additional colleagues to be called in quickly if required. The Trust has also assessed and identified suitable areas for mass decontamination at both hospital sites in collaboration with NHSE, NWAS, and LFRS colleagues. This collaborative approach ensures alignment of HazMat/CBRN plans and procedures with local area plans, thereby enhancing readiness and response capabilities across the region. HazMat and CBRN Response Plan. Decontamination Equipment Capabilities Guideline. Decontamination Audit. ED Rotas Trained Staff List.	Fully compliant			
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://web.archive.nationalarchives.gov.uk/20161104231146https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	The Trust maintains appropriate decontamination equipment to ensure safe patient care and staff protection. An equipment inventory is overseen by the EPRR Team, with regular checks to ensure functionality and readiness. Chorley & South Ribble Hospital has enhanced its facilities to increase capacity for self-presenting patients, while Royal Preston Hospital has a fixed decontamination unit capable of simultaneously treating up to six self-presenters. As a contingency, an articulated decontamination tent is retained on-site at Royal Preston for use during maintenance of the fixed unit. Both sites comply with NHS England guidance by maintaining the required number of PRPS suits, with servicing carried out in line with manufacturer protocols. The Trust is committed to the ongoing maintenance, servicing, and timely replacement of all decontamination equipment. Current PRPS stock will begin to expire in April 2027, and planning for replacement is already underway. Whilst replacement requirements have been identified, the required budget has not yet been formally agreed. The Trust therefore does not currently have full financial assurance that replacement PRPS will be procured and in place ahead of expiry of the existing stock. The replacement PRPS differ from the equipment currently in use and will require relevant colleagues to be trained and competent in their use. Sufficient lead-in time will therefore be required between receipt of the replacement suits and expiry of the existing PRPS to enable an appropriate training programme to be completed and sufficient numbers of trained staff to be maintained. Confirmation of funding and the procurement timeline is required to provide assurance that replacement equipment and associated training will be completed before the existing capability reaches end of life. HazMat & CBRN Response Plan. Decontamination Equipment Capabilities Guideline. Decontamination Equipment Audit.	Partially compliant	Secure formal agreement of the required funding and procurement arrangements for replacement PRPS, with an estimated investment requirement of circa £160,000 at the time of reporting. A delivery timeline should be agreed that ensures replacement suits are available sufficiently in advance of expiry of the existing stock to enable the required number of colleagues to be trained and competent in their use, ensuring continuity of the Trust's decontamination capability.	Corporate risk route, EPRR Committee and capital/planning processes	30.11.2026
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and robe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Preventative maintenance is upheld to ensure continuous readiness for Hazmat/CBRN incidents within the Trust. The ED Team and EPRR Team conduct annual PPM checks, most recently completed in July 2026 by the EPRR Officer and Head of EPRR. Ram-Gene monitors undergo monthly checks by the EPRR Officer as per manufacturer instructions, with annual servicing facilitated by nuclear medicine colleagues and records maintained by EPRR. PRPS are monitored in accordance with Respirex guidelines under the oversight of the EPRR Team. Decontamination facilities undergo annual testing to maintain operational integrity. Other essential equipment is routinely inspected by the ED team and/or EPRR Team, with comprehensive records of all checks kept by the EPRR Team. Details of the PPM process are outlined in the Decontamination Equipment Capabilities guideline, ensuring adherence to industry standards and manufacturer recommendations. This structured approach, including oversight by the EPRR Committee, guarantees that equipment remains operational and ready to respond effectively to Hazmat/CBRN incidents while supporting ongoing business continuity arrangements. Decontamination Equipment Capabilities Guideline. Decontamination Equipment Audit. RamGene Monitoring Log. HazMat & CBRN Response Plan.	Fully compliant			
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	The Trust maintains clearly defined waste management processes within its Hazmat/CBRN plans. For the safe disposal of PPE no longer required, staff render items unusable before collection and disposal by approved contractors, overseen by the Waste Minimisation Officer. Regarding waste water from decontamination, an established Memorandum of Understanding (MOU) with NWAS and Acute hospitals outlines procedures. The Trust contacts NWAS control to engage the on-call Tactical Advisor/NILO, who facilitates arrangements with Veolia for waste water disposal. This process is documented in the Hazmat and CBRN Response plan, ensuring clear and efficient coordination with emergency services. These arrangements align with regulatory requirements and support effective management of Hazmat/CBRN waste, reinforcing the Trust's commitment to environmental stewardship and operational readiness in response to incidents. HazMat and CBRN Response Plan NWAS MOU for waste water disposal.	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that they have undertaken Developed training programme to deliver capability against the risk assessment	Training for Hazmat/CBRN response at the Trust is comprehensive and aligned with our organisational Hazmat/CBRN plan and associated risk assessments. A Training Needs Analysis (TNA) ensures our training programme is tailored to the specific needs of our response staff, particularly focused on decontamination procedures. Currently, we have 62 staff trained in Hazmat/CBRN response, with ongoing efforts to expand this number through a rolling training programme. The Trust is able to evidence that sufficient numbers of appropriately trained staff are available on each shift to form the required decontamination team, providing assurance that the necessary operational response capability can be maintained at all times. Training sessions cover essential areas such as PPE/PRPS use and decontamination practices, delivered both internally and through collaboration with Northern Care Alliance. To ensure continuity and high standards, we have 7 trained trainers within our Emergency Department who facilitate our internal Hazmat/CBRN training programme with support of the EPRR Officer. These trainers have completed PRPS/CBRN Hazmat Train the Trainer Training either through Northern Care Alliance or with NWAS. With delivery of all HazMat and CBRN training moving across to NWAS. All response staff are further supported by an internally developed e-Learning package and ongoing refresher training. Bi-monthly HazMat/CBRN refresher sessions are now fully established at RPH and are delivered jointly by the ED EPRR Lead and the EPRR Officer. These sessions include refresher training on the legal aspects of EPRR, JESIP principles, CBRN and HazMat response, RamGene usage, donning and doffing of PRPS, and a live rehearsal of the decontamination team and decontamination process to maintain familiarity with the decontamination unit. A programme of work has also commenced at CDH, with equivalent sessions being delivered by the EPRR Officer to ensure staff at both hospital sites are prepared and competent to respond to HazMat/CBRN incidents. Training records, including dates of attendance and certification, are held by the ED Clinical Educator, ensuring our staff remain proficient and up-to-date in Hazmat/CBRN response protocols. Figures are also collated by the Trust training compliance team. This structured approach to training ensures our staff are well-prepared to manage Hazmat/CBRN incidents effectively, enhancing both operational readiness and patient safety. HazMat & CBRN Response Plan. HazMat/CBRN Training Records. Blended Learning Figures.	Fully compliant			
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	CBRN awareness training is mandatory for all Emergency Department staff, ensuring they understand the principles of Initial Operational Response (Remove, Remove, Remove) and the need for patient isolation where required. This training forms part of the Emergency Department training programme and is overseen by the Emergency Department Clinical Educator. Emergency Department reception colleagues also receive CBRN awareness training to enable them to recognise potentially contaminated patients, initiate the appropriate escalation process and support the safe management of patients on arrival. The Reception Supervisor is responsible for ensuring new reception staff receive an appropriate induction to these procedures and that any ongoing training requirements are identified and addressed. Staff responsible for patient decontamination receive additional role-specific training to ensure they can safely implement decontamination procedures and maintain a safe system of work during hazardous incidents. The Trust is able to evidence that sufficient numbers of appropriately trained colleagues are available on each shift to form the required decontamination team and maintain the operational response capability for a CBRN/HazMat incident. However, the current Training Needs Analysis (TNA) identifies approximately 118 colleagues as requiring this training, of whom 53% are currently fully trained. Whilst operational cover can therefore be demonstrated, the current level of training compliance against the identified TNA population is not considered sufficient to provide full assurance against the requirements on this Core Standard. HazMat/CBRN Training Records. Blended Learning Figures. CBRN eLearning.	Partially compliant	EPRR to work with the relevant Divisional and Emergency Department teams to review and validate the current Training Needs Analysis (TNA), including the number and roles of staff identified as requiring CBRN/HazMat training, to ensure the identified training requirement is accurate, proportionate and achievable. Following validation of the TNA, an appropriate trajectory will be agreed to improve training compliance and provide assurance that sufficient trained staff are maintained across all shifts to support the required operational response capability.	EPRR Committee and CBRN/HazMat operational assurance	31.12.2026
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	FFP3 masks and full PPE are readily accessible across the Emergency Department at Royal Preston Hospital (RPH) and Urgent Care/Emergency Department at Chorley District Hospital (CDH), supplemented by additional surge capacity throughout the trust. Fit mask testing is conducted routinely across all trust areas, accompanied by regular training sessions overseen by the Clinical Education Team. Both RPH and CDH hospitals maintain the minimum required number of operational PRPS, available around the clock. These suits undergo regular maintenance by Respirex, ensuring compliance with service and expiry dates, as well as necessary filter/battery changes. The EPRR Team maintains detailed records related to PRPS maintenance. The HazMat and CBRN Response plan specifies the location of PPE and outlines appropriate usage based on risk assessments. Additionally, the Decontamination Equipment Capabilities guideline provides comprehensive instructions on PRPS use. HazMat and CBRN Response Plan. Fit Mask Compliance Figures. Decontamination Equipment Capabilities Guideline. PRPS Maintenance Log.	Fully compliant			
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	The Trust incorporates HazMat/CBRNe arrangements into its wider EPRR training, exercising and assurance programme, with a structured schedule of exercises designed to validate and enhance response capabilities. At Royal Preston Hospital, bi-monthly HazMat/CBRNe training and exercising sessions are delivered by the Emergency Department CBRN Lead and the EPRR Officer. These sessions include the donning of PRPS and activation of the decontamination unit to maintain staff competence and familiarity with operational procedures. At Chorley and South Ribble Hospital, a HazMat/CBRNe awareness session was delivered to Emergency Department colleagues in June 2026 by the EPRR Officer, with further training and exercising sessions planned across both sites as part of the Trust's ongoing programme of continuous improvement and preparedness. Since the last reporting period, Trust colleagues have also responded to a number of live HazMat/decontamination incidents at Royal Preston Hospital, successfully deploying the decontamination unit and RamGene as part of the operational response. Debriefs have been undertaken following these incidents, with lessons identified captured and incorporated into future training, exercising and response arrangements to support continuous improvement. Exercise Schedule. Debrief Report.	Fully compliant			

Ref	Domain	Standard name	Standard Detail	Supporting information - including examples of evidence	Organisational Evidence	Self assessment Risk	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance Domain 2 - Duty to risk assess Domain 3 - Duty to maintain Plans										
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance, legislation and regulatory requirements, the Trust has established arrangements to control access and egress for patients, staff and visitors during incidents affecting its premises and key assets. The Trust maintains an overarching Lockdown/Controlled Access Plan, overseen by the Estates and Facilities Directors Security Management Specialist. The Plan is regularly reviewed and exercised to ensure it remains effective and fit for purpose. In May 2020, the Trust implemented its lockdown procedures in response to malicious calls received by the organisation. A structured defined test was undertaken following the incident, with lessons identified being incorporated into future planning and ongoing improvements to the Lockdown/Controlled Access Plan and visitor assurance arrangements. The ICB is satisfied that the Trust meets the requirements of this Core Standard. However, the May 2020 activation highlighted that some areas of the Trust estate remain reliant on manual lockdown arrangements, requiring Security colleagues, supported by Hosting colleagues where necessary, to physically secure identified doors and access points. Whilst the current arrangements enable the Trust to implement lockdown, the reliance on manual intervention can affect the speed and efficiency of securing the site and requires staff to physically attend access points during an incident, potentially increasing their exposure to risk. There is also a reliance dependency on the continued availability of sufficient Security and supporting resources. Should this resource be reduced or otherwise compromised during an incident, the Trust's ability to achieve full lockdown could be affected. Further investment in electronic access control and lockdown capability would therefore improve the speed, efficiency, safety and resilience of the Trust's existing arrangements and reduce reliance on manual intervention.	Partially compliant	Under take a review of current electronic access control and Facilities arrangements across the Trust estate to identify areas reliant on manual intervention and assess opportunities to increase electronic access control capability. Findings to inform a coordinated, risk-based programme of improvements and associated equipment requirements, with consideration	EPRR Committee and a dedicated compliance reporting	31.03.2027	
Domain 4 - Command and control										
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards)	The Trust maintains a 24/7 Tactical and Strategic Commander on-call rota to manage escalations, make decisions and coordinate the Trust response. On-call commanders are expected to undertake NHS England EPRR PhC training alongside the National Minimum Occupational Standards and the Trust's Training Needs Analysis (TNA). Currently, 43% of on-call personnel have completed the NHS England EPRR PhC training, with a programme of training planned to increase compliance across the on-call cohort. Commanders follow defined decision-making processes set out in the EPRR Policy and are supported by the Trust's Incident Response Function.	Partially compliant	The Trust has an EPRR Committee and a dedicated compliance reporting	EPRR Committee and a dedicated compliance reporting	31.12.2026	
Domain 5 - Training and exercises										
22	Training and exercising	EPRR Training	The organisation carries out training in line with the training needs analysis to ensure staff are current to their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on-call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolio for key staff	The Trust delivers and facilitates EPRR training in line with a comprehensive Training Needs Analysis (TNA) to ensure staff remain competent in their emergency preparedness, resilience and response roles. Training requirements are detailed by the EPRR Policy and supported by the EPRR Training and Exercising Programme. The Trust clearly defines the training requirements for on-call personnel, and the wider EPRR team. Training is delivered through a combination of locally facilitated sessions, internal and external training opportunities, nationally available e-learning packages and participation in exercises, with colleagues directed to the training appropriate to their role. A central training record is maintained by the EPRR Team to monitor the evidence, compliance and participation in training and exercises.	Partially compliant	The Trust has an EPRR Committee and a dedicated compliance reporting	EPRR Committee and a dedicated compliance reporting	31.12.2026	
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the National Occupational Standards.	Evidence • Training records • Evidence of personal training and exercising portfolio for key staff	The EPRR Team maintains a central record of training and exercise attendance to support individuals in key response roles achieving the standards required in line with the National Minimum Occupational Standards (NMOS). A comprehensive Training Needs Analysis (TNA) identifies the training requirements for on-call staff and other key responders, ensuring that training is proportionate to their role. Training requirements and compliance are regularly reviewed against the TNA, with the central training record used to monitor completion and identify where further training is required. The Trust continues to offer	Partially compliant	The Trust has an EPRR Committee and a dedicated compliance reporting	EPRR Committee and a dedicated compliance reporting	31.12.2026	
Domain 6 - Response Domain 7 - Resilience and Informatics Domain 8 - Cooperation Domain 9 - Business Continuity										
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • equipment and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Exercise BCPs are developed using the ISO 22301 and the NHS Toolkit. BCP Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Evaluation & Response Structure which is specific to your	Local Business Continuity Plans (BCPs) are in place across services, outlining how each will respond to, manage, and recover from disruptions affecting staff, data, premises, suppliers, contractors, and IT infrastructure. Plans are developed in accordance with the Trust Business Continuity Policy and are aligned with ISO 22301 and the NHS Business Continuity Management Toolkit. The Trust requires BCPs to be reviewed by the identified plan owner at least annually, and additionally following significant organisational change, plan activation, exercises or identified learning.	Partially compliant	BCP owners to complete annual reviews and ensure that Business Continuity Plans are reviewed at least annually	EPRR Committee and a dedicated compliance reporting	31.12.2026	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity exercises.	Confirm the type of exercise the organisation has undertaken to meet this sub-standard • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercises • Test • Undertake a desktop Evidence Post exercise testing reports and action plans	The EPRR Team leads on delivering tabletop exercises using a range of scenarios to test the robustness of service-level Business Continuity Plans (BCPs). As of the reporting date, seven exercises have been completed since the last time of reporting, with further sessions scheduled. The Trust has a well-established business continuity programme, with regular tabletop exercises undertaken across the organisation to validate Business Continuity Plans (BCPs). Each exercise is followed by a structured debrief to identify lessons and opportunities for improvement. Post-exercise reports are issued to services, setting out actions and recommendations. Progress against the exercise programme continues to validate the effectiveness of Business Continuity Plans while promoting assurance that resources identified are implemented and embedded into future planning. The Business Continuity Management System (BCMS), this has contributed to improved organisational engagement and increased compliance with Business Continuity Plan, exercising and audit requirements. In accordance with the Trust Business Continuity Policy, individual BCP owners are also responsible for ensuring that their plans are exercised at least annually, and additionally following significant organisational change or where learning indicates that further testing is required. Whilst there is a established assurance and supporting evidence for exercises facilitated through the EPRR Team, there is currently a gap in central assurance regarding exercises undertaken independently at service level. The EPRR Team does not currently have consistent oversight or evidence to demonstrate that all BCP owners are exercising their plans annually in accordance with the Trust Business Continuity Policy. The Trust is therefore unable to provide full organisational assurance that the annual exercising requirement is being consistently met across all of service-level BCPs.	Partially compliant	BCP owners to ensure that Business Continuity Plans are exercised at least annually, in accordance with the Trust Business Continuity Policy, and that appropriate evidence of compliance is maintained.	EPRR Committee and a dedicated compliance reporting	30.03.2027	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department carries out their compliance with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The Information Technology department has submitted all evidence items for the Data Protection and Security Toolkit for the 2025-26 year. The 2025-26 submission is rated as 'Approaching Standards', with a number of improvement action plans in place addressing the five areas of assurance required to achieve 'Standards Met'. While the department is progressing well, the Trust has not yet achieved 'Standards Met' and there remains a gap in assurance against the requirements of the Core Standard. The Trust is therefore assessed as 'Partially Compliant' pending completion of the identified actions and confirmation that the required standard has been achieved. Confirmation was provided by J. Haggis (Head of Information Governance). Data Protection and Security Toolkit.	Partially compliant	The EPRR Team will strengthen control oversight by recording and Information Governance and Digital Governance	EPRR Committee and a dedicated compliance reporting	30.06.2027	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers, and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BOMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical estate high value suppliers	The Business Continuity Management System (BCMS) outlines the process for obtaining assurance of the business continuity arrangements of commissioned providers and suppliers, ensuring alignment and interoperability with the Trust's own continuity arrangements. This includes a Provider/Supplier Assurance Framework and supplier audit template to support colleagues in obtaining appropriate assurance. Business continuity assurance is increasingly being provided from locally commissioned providers and suppliers where services are procured directly by the Trust, providing greater assurance that appropriate continuity arrangements are in place for those services the organisation is dependent. For nationally procured services and contracts, the Trust has limited oversight of individual supplier business continuity arrangements, as these are managed through the relevant national procurement arrangements. While the Trust is able to seek business continuity assurance from locally procured providers and suppliers, it is not able to obtain the same level of assurance for externally procured services, as this sits outside the Trust's direct control. BC Policy (including BCMS).	Partially compliant	An initial review will be undertaken to identify current arrangements and agree a risk assessment to ensure the third-party services, defining responsibilities and obtaining appropriate business continuity assurance. A register of external business continuity arrangements for critical third-party services will be maintained, with	EPRR Committee and a dedicated compliance reporting	31.03.2027	
Domain 10 - CBRN										
60	Hazmat/CDRI	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of equipment - such as the the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2015/07/hazmat-decontamination-equipment-checklist-01.docx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare settings': https://hazmat.nhs.uk/nationalarchitect.gov.uk/2015/10/23/1487093/view-legend-the-uk-hazmat-checklist-015/04-hazmat-checklist-01.docx	The inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRRPs suits specified by NHS England (24/24). These suits must be maintained in accordance with the manufacturer's guidance. NHS ambulance trusts can provide support and advice on the maintenance of PRRPs suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PRRPs suits, decontamination facilities etc.	The Trust maintains appropriate decontamination equipment to ensure safe patient care and staff protection. An equipment inventory is overseen by the EPRR Team, with regular checks to ensure functionality and readiness. Chertsey & South Middlesex Hospital has enhanced its facilities to increase capacity for self-presenting patients, while Royal Preston Hospital has a fixed decontamination unit capable of simultaneously treating up to six self-presenters. As a contingency, an articulated decontamination tent is retained on-site at Royal Preston for use during maintenance of the fixed unit. Both sites comply with NHS England guidance by maintaining the required number of PRRPs suits, with servicing carried out in line with manufacturer's protocols. The Trust is committed to the ongoing maintenance, servicing, and timely replacement of all decontamination equipment. Current PRRPs stock will begin to expire in April 2027, and planning for replacement is already underway. Whilst replacement requirements have been identified, the required budget has not yet been formally agreed. The Trust therefore does not currently have full financial assurance that replacement PRRPs will be procured and in place ahead of expiry of the existing stock. The replacement PRRPs after the equipment currently in use and will require relevant colleagues to be trained and competent in their use. Sufficient lead-in time will therefore be required between receipt of the replacement suits to ensure the existing PRRPs are used as appropriate training programme to be completed and sufficient numbers of trained staff to be maintained. Confirmation of funding and the procurement timeline is available to provide assurance that replacement equipment and associated training will be completed before the existing capability reaches end of life.	Partially compliant	Severe formal agreement of the route, EPRR repeat funding and procurement arrangements for replacement PRRPs with an estimated replacement requirement of circa £160,000 at the time of reporting. A delivery timeline should be agreed that ensures the replacement suits are available sufficiently in advance of expiry of the existing stock to enable the required number of colleagues to	EPRR Committee and a dedicated compliance reporting	30.11.2026	
64	Hazmat/CDRI	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff may have contact with a potentially contaminated patients, whether in person or over the phone, are authorised to enter a Critical Operational Response (COR) principles, and substitution when staff requirements that are not related to acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of training training programme and designated equipment Evidence that the training includes reference to the relevant current guidance (where necessary) Staff competency records	CBRN awareness training is mandatory for all Emergency Department staff, ensuring they understand the equipment and procedures required. This training forms part of the Emergency Department training programme and is overseen by the Emergency Department recognition colleagues also receive CBRN awareness training to enable them to recognise and respond to potential CBRN incidents. The Recognition Supervisor is responsible for ensuring new recruits staff receive an appropriate induction to these procedures and that any ongoing training requirements are identified and addressed. Staff responsible for patient decontamination receive additional site-specific training to ensure they can safely implement decontamination procedures and maintain a safe system of work during hazardous incidents. The Trust is able to evidence that sufficient numbers of appropriately trained colleagues are available on-call and staff to form the required decontamination team and maintain operational readiness to respond to a CBRN/Hazmat incident. However, the current Training Needs Analysis (TNA) identifies approximately 118 colleagues are required to ensure the team is fully trained, with the current operational capacity being significantly below this number. Therefore the current level of training compliance against the identified TNA population is not considered sufficient to provide full assurance against the requirements of this Core Standard. Additional Training Records: Blended Learning Figures: CBRN Learning	Partially compliant	EPRR to work with the relevant CBRN/Hazmat and Operational Emergency Department colleagues to ensure the current Training Needs Analysis (TNA), including the number and role of staff identified as required for training. CBRN/Hazmat colleagues are required to ensure the current training requirement is accurate, proportionate and achievable. Following validation of the TNA, an operational delivery will be	EPRR Committee and a dedicated compliance reporting	31.12.2026	

Ref	Domain	Standard name	Standard Detail	Supporting information - including examples of evidence	Organisational Evidence	Self assessment				
						Ref	Lead	Timescale	Comments	
						Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.	Action to be taken			
						Amber (partially compliant) = Not compliant with one standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an				

Lancashire & South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2026-2027

STATEMENT OF COMPLIANCE

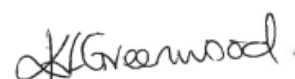
Lancashire Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

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

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

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

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



Signed by the organisation's Accountable Emergency Officer

14/09/2026

Date signed

01/10/2026

Date of Board/governing body
meeting

2026/2027

Date presented at Public Board

2027

Date published in organisations
Annual Report

Emergency Preparedness Resilience Response

**Royal Preston Hospital,
Lancashire Teaching Hospitals NHS Foundation Trust**

September 2026

Annual Report

Emergency Preparedness, Resilience & Response Annual Report – September 2026

Executive Summary |

During 2025/26, the Trust continued to strengthen its emergency preparedness, resilience and response arrangements, with a sustained focus on statutory assurance, organisational learning, business continuity and effective incident response.

Throughout 2025/26, the Emergency Preparedness, Resilience and Response (EPRR) Team supported the organisation in managing a number of incidents including those pertaining to infrastructure and communications failures, hazardous substance presentations, security-related events, a suspected radiological presentation and prolonged industrial action within Blood Sciences. Collectively, these events tested established arrangements in practice, provided assurance in several areas and identified clear priorities for further improvement.

Key developments included strengthening EPRR capacity, progressing the Health Commander training programme, enhancing CBRN/HazMat preparedness, preparing for implementation of Martyn's Law and completing a substantial programme of review across the Trust's principal EPRR plans and procedures. Similarly, the Trust has changed its on call structure and introduced a 24/7 Tactical Management provision delivered via the Trusts Operational Officers complimented by a modified Strategic Command On Call rota membership. These changes provide a greater consistency of response and expertise within its smaller membership.

The Trust has completed its 2026/27 NHS England EPRR Core Standards self-assessment and, following an assurance review with Lancashire and South Cumbria ICB which took place on 8 September 2026. The Trust will report an overall Partially Compliant position. Ten standards have been assessed as Partially Compliant, with action plans identified to support progress towards full compliance.

An independent review of the Trust's EPRR function has also been completed by Mersey Internal Audit Agency (MIAA), resulting in an overall Moderate Assurance rating. The review identified considerable good practice across the Trust's EPRR arrangements, including established policies and plans, governance arrangements, business continuity, exercising, risk management and organisational learning. One High and three Medium-rated findings were identified, with management responses being finalised and actions to be monitored through the appropriate governance arrangements.

Priorities for 2026/27, reflecting the Core Standards assessment, independent audit findings and wider opportunities to strengthen organisational preparedness and resilience, include:

- Improving EPRR training compliance following the introduction of the revised Tactical and Strategic Command arrangements and associated monitoring and assurance;

- Strengthening business continuity assurance, including timely review and exercising of service-level plans and assurance of critical third-party providers;
- Developing a Trustwide incident notification capability;
- Securing the timely replacement of Powered Respirator Protective Suits approaching end of life; and
- Continuing delivery of the Trust's training and exercising programme and preparedness for implementation of Martyn's Law.

Board Assurance Summary |

Assurance area	Current position	Board assurance
Overall EPRR compliance	The Trust will report an overall Partially Compliant position against the 2026/27 NHS England EPRR Core Standards, with ten standards assessed as Partially Compliant and none assessed as Non-Compliant.	Partial assurance can be taken that gaps are understood, have actions identified and are subject to governance oversight.
Independent audit assurance	MIAA has issued an overall Moderate Assurance opinion, identifying good practice alongside one High and three Medium-rated findings.	Moderate assurance can be taken, subject to delivery of agreed management actions and continued reporting through Trust governance.
Operational resilience	Incident responses during the year demonstrated established command, control, business continuity and debrief arrangements.	Positive assurance can be taken from repeated live testing of arrangements, while recognising the need to strengthen mass notification, training compliance and business continuity assurance.
Key residual risks	Residual risks relate principally to Trust wide incident alerting, PRPS replacement, training compliance, service-level business continuity assurance, third-party continuity assurance and DSPT improvement.	Board attention is required where delivery is dependent on resources, cross-divisional engagement or wider organisational prioritisation.

Recommendations to the Trust Board

1. Receive the Emergency Preparedness, Resilience and Response Annual Report and note the assurance provided through incident response, exercising, plan review, audit and governance activity during 2025/26.
2. Note the Trust's overall Partially Compliant position against the 2026/27 NHS England EPRR Core Standards, including ten standards assessed as Partially Compliant and no standards assessed as Non-Compliant.

3. Note the MIAA Moderate Assurance opinion and the requirement to complete and monitor agreed management actions in response to one High and three Medium-rated findings.
4. Support continued executive and committee oversight of the improvement plan through the EPRR Committee, Finance and Performance Committee and relevant specialist governance routes.
5. Endorse escalation of resource-dependent risks, particularly Trustwide incident notification capability and replacement of Powered Respirator Protective Suits, through the Trust's planning and risk management processes.
6. Request a progress update during 2026/27 on delivery of Core Standards, MIAA audit actions and the key strategic EPRR priorities identified in this report.

Compliance

Core Standards 2025/26 – Progress Against Previous Submission

The Trust submitted a Substantially Compliant EPRR Core Standards return for 2025/26. Two standards remained Partially Compliant: EPRR Resource and Assurance of Commissioned Providers'/Suppliers' Business Continuity Plans. Progress has continued against both areas. Recruitment to the additional Band 6 EPRR Officer post was successfully completed, improving resilience within the EPRR function. Work has also continued to strengthen the approach to obtaining assurance that commissioned providers and suppliers maintain current and tested business continuity arrangements.

The ICB assurance process also identified opportunities to strengthen the evidence supporting training portfolios and the formal documentation of business continuity assurance and audit activity. These themes have informed the 2026/27 work programme and are reflected within the current Core Standards assessment, particularly in relation to training compliance, business continuity assurance and commissioned-provider arrangements.

Core Standards 2026/27

The Trust has completed its annual self-assessment against the NHS England EPRR Core Standards for 2026/27. Following review and challenge with Lancashire and South Cumbria ICB on 8 September 2026, the Trust will report an overall Partially Compliant position.

Ten Core Standards have been assessed as Partially Compliant:

- **CS17 – Lockdown:** Current arrangements enable the Trust to implement lockdown; however, some areas of the estate remain reliant on manual intervention. Further work is required to assess opportunities to increase electronic access control capability, improving the speed, safety and resilience of Trustwide lockdown arrangements.
- **CS21 – Trained On-Call Staff:** Compliance with the training requirements for Tactical and Strategic Commanders is not yet fully achieved. The revised command structure and relaunch of the EPRR training programme, supported by migration to Blended Learning, will strengthen training delivery, monitoring and assurance.

- **CS22 – EPRR Training:** Whilst a comprehensive EPRR Training Needs Analysis and training programme are in place, compliance with mandatory EPRR training across key response roles requires improvement. Enhanced monitoring, automated reminders and compliance reporting are being developed through Blended Learning.
- **CS24 – Responder Training:** Training requirements for key responders are established; however, full compliance against the Training Needs Analysis has not yet been achieved. Improved central recording and reporting will support identification and escalation of outstanding requirements.
- **CS47 – Business Continuity Plans:** A comprehensive Business Continuity Management System and central BCP register are in place; however, a small number of service-level plans remain overdue for annual review. These are being actively followed up, with strengthened reporting and escalation arrangements.
- **CS48 – Testing and Exercising:** The Trust has an established risk-based business continuity exercise programme; however, assurance that all service-level BCPs are exercised in accordance with Trust requirements requires strengthening, including improved central oversight of locally undertaken exercises.
- **CS49 – Data Protection and Security Toolkit:** The Trust's 2025/26 DSPT submission is rated Approaching Standards. An improvement action plan is in place to address the remaining areas of assurance and support achievement of Standards Met.
- **CS53 – Assurance of Commissioned Providers/Suppliers:** Further work is required to establish a coordinated, risk-based approach to identifying critical third-party services, defining responsibilities and obtaining proportionate assurance regarding their business continuity arrangements.
- **CS60 – Equipment and Supplies:** The Trust currently maintains the required decontamination capability; however, existing Powered Respirator Protective Suits will begin to reach end of operational life from April 2027. Formal funding and procurement arrangements for replacement equipment are not yet confirmed, and sufficient lead-in time will be required to train colleagues in the use of the replacement suits.
- **CS64 – Staff Training – Recognition and Decontamination:** Sufficient trained colleagues can currently be demonstrated to support the required operational response; however, overall compliance against the identified CBRN/HazMat Training Needs Analysis is not yet sufficient to provide full assurance. The TNA will be reviewed and validated, with an improvement trajectory agreed thereafter.

Core Standards Improvement Action Summary

Standard	Primary issue	Action focus	Assurance route	Completion Due Date
CS17 Lockdown	Variation in estate capability and reliance on manual intervention.	Assess electronic access control opportunities and strengthen staged lockdown arrangements.	EPRR Committee, Security and Estates governance.	31.03.2027
CS21, CS22 and CS24 Training	Training compliance and evidence across commanders and responders requires improvement.	Implement revised TNA, Health Commander programme and Blended Learning compliance reporting.	EPRR Committee and divisional compliance reporting.	31.12.2026
CS47 and CS48 Business Continuity	Some service-level plans and exercises remain overdue or require stronger evidence.	Strengthen trackers, escalation and divisional reporting for reviews and exercises.	EPRR Committee and divisional assurance routes.	30.03.2027
CS49 DSPT	DSPT rated Approaching Standards.	Deliver organisational improvement plan to support achievement of Standards Met.	Information Governance and Digital governance.	30.06.2027
CS53 Commissioned Providers and Suppliers	Third-party business continuity assurance requires a more coordinated risk-based approach.	Identify critical suppliers and agree proportionate assurance requirements and responsibilities.	EPRR Committee with procurement, contracting and divisional governance.	30.03.2027
CS60 Equipment and Supplies	PRPS stock approaches end of operational life from April 2027.	Confirm funding, procurement route and implementation plan, including training lead-in.	Corporate risk route, EPRR Committee and capital/planning processes.	30.11.2026
CS64 CBRN/HazMat Training	Compliance against the identified TNA requires further validation and improvement.	Review TNA, agree compliance trajectory and continue targeted training.	EPRR Committee and CBRN/HazMat operational assurance.	31.12.2026

Action plans and timescales are in place for each area of partial compliance, with progress to be monitored through the EPRR Committee and appropriate Trust governance arrangements.

ICB Assurance Review

The annual EPRR Core Standards assurance review with Lancashire and South Cumbria ICB took place on 8 September 2026. The review provided external challenge and validation of the Trust's self-assessment and supporting evidence across the Core Standards.

Following the review, the ICB agreed the Trust's proposed Core Standards position, with an overall assessment of Partially Compliant and ten individual standards assessed as Partially Compliant. No standards are being reported as Non-Compliant.

The agreed self-assessment and associated action plans will now progress through the Trust's internal governance arrangements, with circulation to the Finance and Performance Committee and Trust Board for approval prior to formal submission to the ICB.

MIAA EPRR Audit

An independent review of the Trust's EPRR function has been completed by Mersey Internal Audit Agency (MIAA), providing additional assurance regarding the controls and processes supporting the Trust's emergency preparedness and business continuity arrangements. The review has resulted in an overall Moderate Assurance opinion.

The audit identified several areas of good practice. MIAA recognised that the Trust has established EPRR and Business Continuity policies which clearly define responsibilities and command arrangements; maintains Trustwide plans aligned with national requirements; has an established annual EPRR work programme and governance structure; and maintains EPRR and Business Continuity risks through the Board Assurance Framework and Corporate Risk Register.

Positive assurance was also identified in relation to business continuity and organisational learning. The Trust's BCP template is aligned with the NHS England EPRR Framework and ISO 22301 principles; a risk-based exercising programme is in place which meets NHS England minimum Core Standards requirements; an annual BCP audit programme is established; and review of recent incident debriefs demonstrated that actions and lessons identified are monitored through the EPRR Committee.

The audit identified one High and three Medium-rated findings. The High-rated finding relates to EPRR training compliance and the completeness of central monitoring arrangements. Medium-rated findings relate to strengthening existing assurance arrangements for service/departmental Business Continuity Plans, particularly the follow-up and escalation of plans overdue for review, business continuity governance for services provided by third parties, and EPRR Committee attendance and quoracy.

Management responses are being finalised for return to MIAA. Actions include completing the migration of EPRR training and compliance monitoring to Blended Learning; strengthening central oversight and escalation of overdue BCP reviews and exercising; developing a risk-based Trustwide approach to business continuity assurance for critical third-party services; and reviewing EPRR Committee membership, attendance and deputy arrangements. Progress against agreed actions will be monitored through the EPRR Committee and appropriate governance arrangements.

Incidents

EPRR supported the Trust through a varied range of incidents and disruptions during the reporting period. The following events are included where they provided material assurance, generated organisational learning or required coordinated business continuity or incident management arrangements.

Multitone Bleep System Outage: 14.08.2025

A significant outage affected the Trust's Multitone bleep system for much of the day. An Incident Management Team was established involving Telecoms, Tactical and Strategic Commanders and EPRR colleagues.

The incident was managed through established contingency arrangements but further reinforced the need for a reliable Trustwide mechanism capable of rapidly alerting large numbers of colleagues during incidents. The emergency mobile distribution arrangements were subsequently reviewed, and Trustwide incident communications remain an area of ongoing development.

RPH Decontamination Responses: August, September, November 2025 and January 2026

Several chemical contamination presentations during the year provided valuable assurance of the Trust's CBRN/HazMat response arrangements.

Presentations involved a range of chemical substances, including hydrochloric acid, sulphuric acid, styrene, afronsin and caustic substances. Emergency Department colleagues demonstrated appropriate triage, safe distancing and decontamination procedures. A further self-presenting patient following hydrochloric acid exposure was managed effectively in January 2026, while one incident in November also required the attending ambulance crew to undergo decontamination due to off-gassing.

Overall, the incidents provided positive assurance regarding staff preparedness and the practical application of established response arrangements, while identifying learning in relation to the management of contaminated clinical environments and liaison with external partners.

Train Derailment: 03.11.2025

The Trust was placed on major incident standby following a train derailment. No casualties were received and the Trust was subsequently stood down; the event nevertheless provided a live test of alerting and preparedness arrangements.

Heating System Disruption: 19.11.2025

A heating system failure affected parts of Royal Preston Hospital. Estates implemented a temporary repair while replacement components were sourced, supported by business continuity measures including additional blankets and linen, hot drinks and clear briefing of Trust Operational Officers on controls and escalation arrangements.

RPH Emergency Department Smoke Ingress: 06.01.2026

Failure within an air-handling unit resulted in smoke entering areas of the Emergency Department and required evacuation of affected clinical areas. Patient care was maintained throughout.

The review identified learning around internal escalation routes and the wording of incident alerts, reinforced the value of structured reporting such as M/ETHANE, and highlighted the continuing need for rapid notification mechanisms for on-call colleagues.

Preston Business Centre - Call Centre Evacuation: 11.03.2026

Damage to ceiling infrastructure required evacuation of the PBC call centre. Business continuity arrangements enabled staff to move to home working using soft-phone and headset arrangements, maintaining outpatient services remotely while staff welfare support was made available.

The response provided practical assurance that established business continuity arrangements could sustain service delivery following loss of the normal workplace.

Suspected HCID/VHF Presentation: 23.04.2026

A suspected High Consequence Infectious Disease/Viral Haemorrhagic Fever presentation resulted in activation and subsequent review of relevant arrangements.

The debrief identified a need to strengthen travel screening at the first point of contact and during triage to support earlier recognition and escalation of potentially high-risk presentations. Improved travel screening crib sheets were subsequently issued to reception and triage colleagues.

The incident also reinforced an existing operational challenge relating to the lack of a dedicated Emergency Department isolation room with en-suite facilities.

Malicious Threat/Lockdown: 05.05.2026

A malicious threat resulted in lockdown procedures being implemented at Royal Preston Hospital.

The subsequent debrief identified delays in escalation to the Strategic Commander and Security and highlighted the importance of ensuring that escalation arrangements are clearly understood by all relevant colleagues.

The event also exposed limitations in the Trust's ability to issue rapid, widescale incident notifications. A multidisciplinary workstream involving Digital, Telecoms, Security, Estates and Comms is therefore considering options to strengthen this capability.

Additional security mitigations have also progressed, including enhanced staged lockdown functionality, improvements to door monitoring and further work to strengthen Emergency Department lockdown capability.

Planned High Voltage Maintenance: 05.06.2026-07.06.2026

Extensive planning was undertaken ahead of essential high-voltage maintenance at Royal Preston Hospital, recognising the potential impact of power interruption on clinical and operational services.

The programme included detailed project and risk assessments, temporary generator arrangements, operational sequencing, communications planning and divisional business continuity preparation. Colleagues were reminded of downtime packs, manual processes and local contingency arrangements.

The planned works were partially completed. A temporary power interruption occurred following a breaker issue; however, contingency arrangements operated effectively and no patient harm was reported. A debrief was completed to capture learning, and planning is underway to complete the outstanding works.

Springfield Radiological Incident: 06.06.2026

Three patients presented following a suspected radiological incident. No contamination was ultimately identified, and the operational response was considered appropriate.

The after action review identified learning relating principally to communication and pre-alert arrangements between the ambulance service and operational colleagues within the Emergency Department. The debrief has been completed, with identified actions circulated to relevant colleagues for review and implementation.

Blood Sciences Industrial Action: June/July/August/September 2026

Prolonged industrial action within Blood Sciences represented the most sustained business continuity challenge of the reporting period and resulted in escalation to a Critical Incident.

The service remained extremely fragile throughout the industrial action, with derogation requests initially used to protect critical activity until these were subsequently withdrawn by the trade union. Daily Incident Management Team meetings were established to provide command, control and operational oversight, supported by continued engagement with operational leaders, EPRR colleagues, trade union representatives and system partners.

Contingency arrangements were continually reviewed and adapted to protect urgent and clinically essential testing while managing available laboratory capacity and wider service pressures. These arrangements included the use of external laboratory support and associated transport and operational processes, alongside management of the impact on primary care activity.

The response has generated significant organisational learning in relation to prolonged business continuity disruption, workforce dependency, command and

control, external laboratory support, transport arrangements, escalation and system-wide communications.

At the time of reporting, the industrial action remains ongoing. An in-action review is planned to capture good practice and identify learning from the response to date. Following conclusion of the industrial action, a formal after action review/debrief will be undertaken to capture learning from the full incident response and identify any further improvements required to strengthen future business continuity and incident response arrangements.

Across all incidents, lessons identified through debrief and after action review processes continue to be recorded and monitored through the EPRR Action Tracker and EPRR Committee to provide organisational oversight and assurance.

EPRR Training & Exercising Programme

Training

EPRR Awareness - EPRR awareness, previously embedded within the Trust's Fire Safety eLearning package, has been established as a standalone mandatory module for all staff. This supports a consistent baseline understanding of emergency preparedness resilience and response, and greater visibility and assurance of EPRR training compliance.

Health Commander EPRR Training Programme - A significant programme of work has taken place during the year to strengthen training and assurance arrangements for Strategic and Tactical Commanders.

A revised Training Needs Analysis and Commander Portfolio have been developed, and work is progressing with the Blended Learning Team to provide a centralised training package and improved compliance reporting.

Training requirements have been communicated to Tactical and Strategic Commanders, with the programme designed to provide clearer evidence that colleagues undertaking command roles have completed the training appropriate to their responsibilities.

The 2026/27 Core Standards assessment has confirmed that training compliance remains below the required level and is a key area for improvement. Improving completion and the associated evidence base will therefore remain a priority during 2026/27.

Legal Awareness - Legal awareness training has continued to be made available to Strategic and Tactical Commanders and other colleagues who may support the Trust's incident response arrangements. Face-to-face sessions have been supplemented by an eLearning option where required.

Martyn's Law / Terrorism (Protection of Premises) Act

Significant progress has been made during the reporting period in preparing the Trust for implementation of the Terrorism (Protection of Premises) Act, commonly referred to as Martyn's Law.

A structured, tiered training approach has been developed in conjunction with the Trust's Blended Learning Team:

Level 1 – Counter Terrorism Awareness

A mandatory awareness package has been developed for all Trust colleagues. The approximately 15-minute package covers threat awareness, escalation to Security, relevant signposting and the principles of Guide, Shelter and Report. The mandatory package was implemented on 4 August 2026.

Level 2 – Enhanced Counter Terrorism Training

ACT (Action Counters Terrorism) Awareness eLearning package will be mandatory for colleagues working within identified higher-risk areas, including Emergency Departments, reception areas and other high-footfall locations.

Level 2a – Counter Terrorism Policing Training

Face-to-face training delivered by Counter Terrorism Policing will continue to supplement the Trust's internal programme and provide enhanced awareness for relevant colleagues.

The Trust has also continued to work closely with Security colleagues to strengthen organisational preparedness. Hostile Information Plan assessments have supported understanding of site vulnerabilities, while the wider security team continues to progress the physical and procedural requirements associated with future compliance.

The Trust's approach has been recognised as being advanced compared with neighbouring organisations, and the internally developed eLearning package will be shared across Lancashire and South Cumbria to support wider system preparedness.

CBRN/HazMat Training - Considerable work has continued to strengthen CBRN/HazMat preparedness.

Local refresher and familiarisation sessions have been developed to bridge the gap between formal external training and the practical arrangements colleagues would be required to implement within RPH and CDH.

Training has included:

- local response arrangements and plans;
- decontamination routes;
- Entry Control Officer familiarisation;
- use of Powered Respirator Protective Suits;
- JESIP awareness;
- health and safety requirements; and
- practical decontamination response.

Two full-day CBRN/HazMat awareness sessions were delivered by NWS on 20 and 30 April 2026 for colleagues who would not normally form part of a decontamination team but may encounter or subsequently care for an affected casualty. The sessions covered recognition of CBRN/HazMat impacts and

symptoms, treatment considerations, available specialist support and learning from previous incidents, and received positive attendance and feedback.

Training specifically for Emergency Department reception colleagues has continued to improve awareness at the first point of contact, supporting early recognition and appropriate escalation of patients potentially requiring decontamination.

The 2026/27 Core Standards assessment has identified CBRN/HazMat training compliance as an area requiring further improvement. While sufficient trained colleagues can currently be demonstrated to support the required operational response, overall compliance against the identified Training Needs Analysis is not yet sufficient to provide full assurance. The TNA will therefore be reviewed and validated, with an improvement trajectory agreed and monitored through the EPRR Committee.

Exercising

The Trust maintained an active exercising programme throughout the reporting period, using a combination of business continuity, communications, cyber and specialist emergency preparedness exercises. The programme provided opportunities to test both Trustwide response arrangements and service-level business continuity plans across a range of realistic scenarios.

Exercise	Date	Scenario/Purpose
RPH ED Lockdown	Sept 2025	Unannounced exercise to test Emergency Department lockdown arrangements
Exercise Advent	Dec 2025	Communications cascade exercise to test commanders' awareness of action cards and Incident Coordination Centre arrangements.
Exercise Ash	Dec 2025	Six-monthly communications cascade exercise
Cardiology Business Continuity	Jan 2026	IT and power outage
Diabetes & Endocrinology Business Continuity	Feb 2026	Reduced staffing and IT outage
SMRC Business Continuity	Feb 2026	Denial of access to premises and IT outage
Cyber Tabletop	Mar 2026	Cyber incident response
Critical Care Business Continuity	April 2026	Reduced staffing and IT outage
Exercise Unexpected Arrival	Apr 2026	HCID/VHF response
Communications IRP & Business Continuity Exercise	Apr 2026	Adverse weather and IT outage scenario to validate the Communications Incident Response Plan and exercise local business continuity arrangements.
Exercise Mayday	May 2026	Six-monthly communications cascade exercise
Exercise Toucan	May 2026	NHS England annual comms exercise
SAFE Centre Business Continuity	Aug 2026	Denial of access to premises

The programme provided broad coverage across both corporate and clinical services, with business continuity exercises testing common disruptive scenarios including IT and power disruption, reduced staffing and denial of access to premises.

Specialist exercises also tested arrangements for lockdown, cyber response, HCID/VHF and incident communications.

Exercise Unexpected Arrival, undertaken on 23 April 2026, tested the Trust's procedures for managing a patient presenting with suspected Viral Haemorrhagic Fever (VHF) or other High Consequence Infectious Disease (HCID). The multidisciplinary tabletop exercise involved colleagues from the Emergency Department, Infection Prevention and Control, Microbiology and Domestic Services.

The exercise demonstrated good awareness of the principles of early identification, isolation and escalation, with participants appropriately referencing the Trust's HCID/VHF procedures throughout the scenario. Learning was identified in relation to ambulance pre-alert arrangements, staff awareness of PPE locations and action cards, availability of trained staff, travel screening processes and the limitations associated with the absence of a designated isolation facility. Actions arising from the exercise have been incorporated into the EPRR Action Tracker and are being progressed through established governance arrangements.

Operational pressures resulted in some planned exercises being cancelled or postponed during the reporting period. Divisions continue to be encouraged to prioritise exercising as part of routine business continuity assurance.

Learning and actions arising from exercises are captured through formal debriefing arrangements and monitored through the EPRR governance structure. The forward programme includes an EMERGO Mass Casualty Exercise in November 2026, a Counter Terrorism Exercise with ED in March 2027 and a Pandemic Exercise in April 2027.

Plans, Policies & Procedures

A substantial review programme has been completed to keep the Trust's EPRR framework aligned with national guidance, organisational arrangements and learning from incidents and exercises.

Documents reviewed and progressed during the reporting period include:

- Major Incident Plan;
- Pandemic Plan;
- Trust Decant Plan;
- EPRR Policy;
- Business Continuity Incident Response Plan;
- HazMat and CBRN Response Plan;
- Countermeasures Plan;
- EPRR Training Guidance; and
- Tactical and Strategic Commander Standard Operating Procedure.

The Tactical and Strategic Commander SOP has also undergone external legal review, with positive feedback received.

Responsibility for the VHF/HCID Policy has transferred to Infection Prevention and Control, with EPRR continuing to provide specialist input. The policy has subsequently been reviewed and updated to reflect learning identified through Exercise Unexpected Arrival, alongside changes in national guidance. PPE

arrangements have also been updated in accordance with revised guidance, with additional equipment made available within both Emergency Departments.

The review cycle will continue to ensure plans remain current and that material learning is incorporated through the appropriate governance route.

Business Continuity Plans

Business continuity remains under active EPRR Committee oversight, supported by a monthly BCP tracker and divisional assurance.

The tracker identifies plans approaching or exceeding their review date and supports targeted follow-up with divisions.

The August 2026 tracker review showed that most divisions had no overdue plans. Medicine had four plans overdue for review, Diagnostics and Clinical Services had two and Corporate had two. These areas are being followed up through divisional escalation and EPRR Committee reporting.

The Trust has continued to mature its Business Continuity Management System through internal audit, exercising and improved divisional assurance. The associated corporate risk was reduced during the year following review of current gaps, controls and assurances. The MIAA review recognised the established BCP audit and risk-based exercising programmes, while identifying an opportunity to further strengthen follow-up, escalation and assurance where individual service-level reviews or exercises are overdue.

Strategic Risk and Mitigation Summary

Risk area	Potential impact	Current mitigation	Further action
Trustwide incident alerting	Delayed or inconsistent communication during incidents.	Existing command structures, action cards, telecoms arrangements and incident communications processes.	Develop options appraisal for mass notification capability and agree implementation route.
PRPS replacement	Reduced specialist decontamination capability if replacement stock is not secured before expiry.	Current operational stock, local training and escalation through risk and governance routes.	Confirm funding, procurement and training plan ahead of April 2027.
Training compliance	Reduced assurance that all responders and commanders are trained in line with role requirements.	Revised TNA, commander portfolio and Blended Learning migration.	Agree compliance trajectories and routine reporting to governance committees.

Business continuity assurance	Variation in readiness across services and third-party dependencies.	BCP tracker, audit programme, exercising and divisional oversight.	Strengthen escalation for overdue plans and implement third-party assurance framework.
DSPT improvement	Reduced digital resilience assurance where standards are not yet fully met.	Organisational improvement plan led through information governance arrangements.	Continue monitoring to support achievement of Standards Met.

Strategic Risks and Priorities

Trustwide Incident Alerting and Communications

The absence of a single Trustwide mass notification capability remains a significant operational risk, reinforced by learning from the bleep outage, smoke ingress and lockdown events.

Current arrangements do not provide a sufficiently rapid and coordinated means of alerting command staff while also issuing targeted or Trustwide instructions during incidents.

Digital, Telecoms, Security, Estates and Communications are exploring options including automated push notifications, mass telephony, public address capability and targeted area messaging.

Powered Respirator Protective Suits

Replacement of the Trust's Powered Respirator Protective Suit stock is a significant forthcoming requirement.

Existing suits will begin to reach end of operational life from April 2027. Timely replacement is required to maintain specialist decontamination capability at RPH and CDH and meet the Trust's emergency preparedness responsibilities.

The requirement has been escalated through the appropriate governance routes and a specific risk is being developed to ensure the potential operational and compliance consequences of failing to secure replacement equipment are clearly understood.

This position is reflected within the 2026/27 Core Standards assessment, with CS60 – Equipment and Supplies assessed as Partially Compliant pending confirmation of replacement arrangements and sufficient lead-in time for associated training.

Business Continuity

Business continuity arrangements have continued to mature; however, timely completion and exercising of service-level plans and assurance of critical third-party arrangements remain areas requiring continued oversight. These priorities are reflected within both the 2026/27 Core Standards assessment and MIAA audit findings and will continue to be progressed through the EPRR work programme.

Training Compliance

Training compliance for Strategic, Tactical and Operational Commanders and relevant responders remains a key assurance priority and is reflected within the final 2026/27 Core Standards assessment and MIAA audit findings. Improved reporting through Blended Learning, individual compliance trajectories and the revised Health Commander programme will strengthen oversight and support progress towards full compliance.

Data Security and Protection Toolkit

The Trust's 2025/26 Data Security and Protection Toolkit submission is rated Approaching Standards and is therefore reflected as Partially Compliant within the 2026/27 EPRR Core Standards assessment. An organisational improvement plan is in place to address the outstanding requirements, with progress led through the appropriate information governance arrangements.

Resource & Funding

EPRR Function

The resilience of the EPRR function has improved during the reporting period following successful recruitment of an additional Band 6 EPRR Officer. This has reduced the previous single person dependency within the service and increased capacity to support the Trust's training, exercising, incident response, business continuity and assurance programmes.

However, the function continues to require administrative support from the Capacity Management Admin Team and further consideration of the longer term resource model is required to ensure sufficient capacity to meet the Trust's statutory and operational EPRR responsibilities.

Future delivery of the EPRR work programme will require consideration of a number of potential financial pressures, including:

- PRPS replacement
- Training delivery
- Exercising programme
- Mass notification solution

These requirements will continue to be developed and escalated through the appropriate planning and governance routes as costs and implementation requirements become clearer.

Delivery of actions arising from the 2026/27 Core Standards assessment and MIAA audit will also be kept under review for any additional resource implications.

Conclusion and Forward Look

Overall, the reporting period provides evidence of a maturing EPRR framework that has been tested repeatedly in practice. Responses to significant operational disruption have generally demonstrated effective local arrangements, while debriefing, exercising and assurance activity have identified specific areas where further organisational improvement is required.

For 2026/27, the Trust will report an overall Partially Compliant position against the NHS England EPRR Core Standards. This represents a change from the previous year's Substantially Compliant position and should be understood in the context of more detailed evidence review, strengthened assurance expectations and specific gaps requiring further action. The assessment has been reviewed and agreed with Lancashire and South Cumbria ICB, with actions identified against each area of partial compliance. There is no immediate indication from the assessment that established response arrangements are ineffective; however, the position confirms that further work is required to provide full assurance across all standards.

This position should be considered alongside the independent MIAA review, which has provided an overall Moderate Assurance opinion. The audit identified considerable areas of good practice across the Trust's EPRR arrangements, while identifying one High and three Medium-rated findings requiring further action. These principally relate to training compliance and monitoring, strengthening existing assurance and follow-up arrangements for service/departmental Business Continuity Plans, business continuity governance for services provided by third parties, and EPRR Committee attendance and quoracy.

The 2026/27 work programme will focus on addressing the identified Core Standards and audit actions while continuing to progress wider strategic priorities, including Trustwide incident notification, PRPS replacement, business continuity assurance, training and exercising, and implementation of Martyn's Law. Progress will continue to be monitored through the EPRR Committee and appropriate Trust governance arrangements.

Glossary

Term	Meaning
BCP	Business Continuity Plan.
CBRN	Chemical, Biological, Radiological and Nuclear.
CDH	Chorley and South Ribble Hospital.
DSPT	Data Security and Protection Toolkit.
EPRR	Emergency Preparedness, Resilience and Response.
HazMat	Hazardous Materials.
HCID	High Consequence Infectious Disease.
ICB	Integrated Care Board.
JESIP	Joint Emergency Services Interoperability Principles.
MIAA	Mersey Internal Audit Agency.
PRPS	Powered Respirator Protective Suit.
VHF	Viral Haemorrhagic Fever.

Report End
Sam Hughes | Head of EPRR

14.1 DATA QUALITY ASSURANCE REPORT

● Information Item

REFERENCES

Only PDFs are attached



14.1 Data Quality Assurance Statement Board Pt I October 2026.pdf



Board of Directors Report

Meeting of the	Board of Directors	October 2026
	Part I ☒	Part II ☐
Title of Report	Data Quality Assurance Report	
Report Author	Phil Capps, Head of Business Intelligence & Tracy Caton, Data Quality Assurance Manager	
Lead Executive Director	Stephen Dobson, Chief Information Officer	
Recommendation/ Actions required	The Board of Directors is asked to: note current Data Quality Assurance activities and the on-going developments that support further improvements to data quality assurance processes and data quality clinical engagement.	
	Decision ☐	Assurance ☐ Information ☒
Executive Summary	The paper informs the Board in relation to current data quality assurance activities and provides an update in relation to data quality performance. The Report details performance in relation to: • Data Quality Team activities • External Data Quality Assurance • Update in relation to Data Quality Risks • Waiting List Minimum Dataset Data Quality • National Data Quality Assurance Dashboard and Maturity Index	
Link to Strategic Objectives 2026/27	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☐
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☐
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Appendices (These must be sent as separate pdfs and will be placed in the Ancillary Pack)	State whether there are any appendices and list them. For example: Appendix 1: DQM Index	

1. Background / context or introduction

The benefits of using routine health care data for planning, policy making, and research, future demand, and quality of service are well established. Using data for these purposes requires that data is high quality, timely, complete and accurately coded. As part of Board Assurance and in response to actions identified in the Trusts Well Led Review this paper sets out the effective processes used to monitor, manage and report on the quality of data.

This report provides an overview of current data quality assurance activities within the Trust to assure the quality of data used for reporting.

Data quality is defined as the state of accuracy, completeness, reliability, validity, timeliness and systemic consistency that makes data fit for purpose. Acceptable data quality is crucial to operational processes and to the reliability of Trust performance reporting. The use of high-quality information leads to better decision making to improve patient care and safety.

Poor data quality puts organisations at significant risk in terms of damaging stakeholder trust, weakening frontline service delivery, incurring financial loss, poor forward planning and poor value for money.

Data Quality Assurance (DQA) compliments and underpins the principles of Information, Clinical, Research and Corporate Governance, which ensure that personal data is dealt with legally, securely and efficiently, in order to deliver the best possible care. The current climate of scrutiny from audit bodies and the Information Commissioner's Office enforces the requirement, with significant risk of potential fines for non-compliant practice.

2. Discussion

Overview of all facets of data quality assurance and actions to date undertaken to maintain data quality standards within the Trust included within ancillary paper

3. Financial implications

None

4. Legal implications

None

5. Risks

Highlighted in ancillary paper

6. Impact on stakeholders

not applicable

7. Recommendations

The Board is asked to note current Data Quality Assurance activities, internal and external monitoring processes and the on-going developments that support further improvements to data quality assurance and data quality engagement.



Board of Directors Report

Data Quality Assurance Update Report – October 2026

Internal and External Scrutiny

Information Governance

Information Governance (IG) is the way in which the NHS handles all organisational information - in particular the personal and sensitive information of patients and employees. Information Governance provides a framework that ensures information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. The DQA team continues to undertake data quality assurance initiatives to support IG compliance and the delivery of quality assured data collection and collation processes.

The Data Protection and Security Toolkit has been aligned with the Cyber Security Framework and the data quality requirements are included within the objective '*evidence around essential functions data being monitored to verify location and transmission, quantity and quality*' rather than a separate requirement. Evidence relating to the audit and validation programme has been supplied for the baseline submission. MIAA initial audit has been completed and (report pending). positive final report received advising of a low-risk rating and a high confidence in the Trust's DSPT assessment.

Data Quality Assurance Activities

Harris Flex Masterfile Maintenance

The Trust is working with Harris Flex to implement a programme of work to update all Commissioner allocation master files to the latest version available. This includes:

- Postcode
- GP and Practice
- Health Authority
- Clinical Commissioning Groups (CCG's)

Work remains ongoing on Harris Flex Test system to finalise robust process to ensure Flex reference tables are consistent with national standards and incorporate the latest available updates. The work is monitored through the Harris Flex Customer Care Board as appropriate. The work of the group will seek to minimise system data quality risks as well as improve SUS activity reporting. It is expected that once the work is complete quarterly updates to masterfiles will move into business as usual process.

This will address the issues raised in Risk 54 GP Masterfile maintenance on Harris Flex.

Data Quality audit programme

Demographic Audits: - audits of patient demographics and link to the reception audits in order to ensure details are being collected and amended correctly on CPR at point of reception.

Reception Point Audits: - the objective of the audits is to continue to monitor compliance against key data indicators, procedural documentation, Information Governance principles, support corporate projects and highlight areas for further training/improvement. As part of the audit, adherence to the 'check-in' process and verification / update of patient demographic and GP details is reviewed. This is an essential requirement at each hospital attendance to ensure we have captured the correct commissioning data - thus negating validation and supports minimising PbR pressures and delivery of clinical documentation to correct GP practices.

2026/27:	Total Complete:	Total CA Sent:	Total CA Received:	DQA Closed	CA Outstanding:
Completed OPT Demographic Audits	31	28	2	0	26
Completed IP Demographic Audits	0	0	0	0	0
Completed ED Demographic Audits	10	10	9	0	1
Completed Reception Audits	0	0	0	0	0
Totals:	64	38	11	0	27

Shared Care Record - ShCR – update

The ShCR project aims to establish data interoperability across the health and social care system in Lancashire. The process allows the exchange of personal identifiable data, including discharge summaries, PACS images, patient care summaries, medication information and clinical correspondence.

Currently the following documents are being transferred electronically direct to GP systems within the Northwest Region catchment area: -

- Immediate Hospital Discharge Information produced from Harris Flex
- Trauma & Orthopaedic and Colorectal clinic letters
- Advice & guidance documents
- GP Patient Death Notifications
- Discharge summaries from Maternity
- Clinic letters for majority of specialities utilising digital dictate system (TPro)

The DQA team monitor rejected records, updating patient details where necessary and ensuring timely receipt of clinical information. Rejected records are resent either electronically to the correct practice following review and update on Harris Flex or printed and posted if the practice is not part of ShCR.

The table below shows a summary of records transferred via ShCR for the GP practices April 2026 – August 2026.

Month	Total Records Sent	Total Rejected	% of records	No. EMIS issue	No. True Rejections (inc NOP, dupes etc)	True rejections as a % of all records sent	True rejections as a % of rejected records
April	65970	1451	2.20%	187	1264	1.92%	87.11%
May	63240	1269	2.01%	112	1157	1.83%	91.17%
June	73862	1372	1.86%	217	1155	1.56%	84.18%
July	72056	1630	2.26%	500	1130	1.57%	69.33%
August	63221	1162	1.84%	174	988	1.56%	85.03%
Total	338349	6884	1.63%	1190	5694	1.68%	82.71%

Rejection Reasons:-

- Not registered at GP practice IHDI sent to
- Baby – delay in registering at GP practice

- GP patient registered with practice, not on SCR system
- Duplicate IHDIs being sent to Practices

There are minimal numbers of summaries being posted for GP practices that are not currently part of ShCR. Savings on consumables and posting for discharge summaries and letters achieved to-date in this financial year is £79,913.30

The transfer of all clinical documentation (via the digital dictation process) onto ShCR is complete across all specialities. The volume of documents being posted has decreased and savings increased. However, there is an impact on the DQA team and the volume of rejections requiring review, update and resending.

Due to the increased volume of documents and external partner issues across the system, resulting in increased rejections, pressure on the DQA team and potential patient clinical safety risk, a corporate risk assessment (2175) has been logged onto Ulysses and is reviewed quarterly by the ShCR steering group and the Digital Health & Informatics Risk Management Group.

Data Completeness and Validity

The Data Quality Assurance Team has a key role in identifying missing and incomplete documentation that directly impacts on activity and income levels. This role includes highlighting to divisions outpatient appointments that have not been documented as either patient attended or Did Not Attend and gives divisions the opportunity to action these historical appointments on the system.

The tables below show the volume of activity in Q1-Q3 2025-26 identified and updated by the DQA team:

Month 2026-27	Attended	DNA	Cancelled	Pended
April	361	145	8	553
May	201	124	6	453
June	193	159	7	385
July	205	100	20	426
Total Appts	960	528	41	1817
Average	240	132	10	454

There has been an increase in the volume of appointments not fully documented, resulting in a further increase in the number of records requiring review and update on Harris Flex. However, there is still ample scope for further improvement to ensure records are recorded in real time or as near to it as possible.

There is also an increase in the volume of admissions left as pended/active on Harris Flex, the DQA team review weekly admissions and update Harris flex with the correct discharge dates.

Month 2026-27	Active SP/IP (visit missing discharge date)	Pended SPs (visit missing for activity/coding)	Incorrect Disch date
April	120	9	98
May	131	15	116
June	147	30	71
July	89	18	88
August	118	22	88
Total visits	629	128	484

Data Quality Newsletters

The Data Quality Assurance team have published 1 newsletter in April 26 giving an update on:

- Data Quality
- DQ/IG Presentations

- DQA department role
- Patient demographics – recording correctly
- Flex patient records
- Hospital Discharge Summaries
- Updates on the SCR(LPRES) project
- Meet the team
- Recycling data

Data Quality Forums

The DQA management team attend the quarterly North West Data Quality Summit meetings and subscribe to the online forum where key data quality issues are discussed, presentations around a variety of topics and key developments. This allows the team to evaluate, compare and identify areas of best practices and any changes required to improve the DQA program.

Examples from last 6 months:- Discussions on data platforms, data quality function and ethnicity reporting.

Data Quality Risks

The Data Quality Assurance Team undertake regular audit tasks to identify risk areas, working with services to implement remedial/improvement actions through the corporate quality improvement programme. A full risk assessment has been completed for each item; these are held locally on the Business Intelligence Risk Log.

The Team continue to monitor the key risks and remedial actions identified to sustain improvements and minimise risks. The table below shows the current risks to key data quality items and how they are being mitigated.

RA No	Risk Item	Issue	Actions 2026-27	Update
54	Harris Flex GP Masterfile maintenance (current rating 12)	In-active GPs linked to patient records. In-accurate GP records in Masterfile on Harris Flex. Continued misdirected correspondence.(NOPs).	Move to ODS quarterly updates. Increase volume of documents transferred via SCR.	Harris flex team working with BI & DQA to establish process to upload files onto TEST PROD. Standing item on bi- weekly applications call with Harris team.
122	Corporate system recording issues. In-accurate recording of patient data/activity (current rating 12)	Variety of in-accurate event documentation. Incomplete linking across activity flows.	Review SUS issues on key data items. Continue to review functionality to improve correction of data on Harris Flex. Establish data quality forum	Further additional Harris flex validation reports implemented. Working on supporting divisions with identifying reasons for issues with activity recording. Working with BI on SUS errors highlighted.
1207	Inability to meet the monthly clinical coding submission standards (current rating 12)	Non-availability of comprehensive coded data. Timeframe for reviewing / coding data.	Medicode upgrades Recruit to senior coder roles Recruit to coder trainer position	Latest upgrade completed July 26 Interviews due Sept 2026 Awaiting approval to go out to advert
1554	Inability to fully run the Trusts Data Quality programme (current rating 12)	Volume of in-accurate patient records on core patient system Harris Flex. Increase in number of rejections from sending clinical documentation via ShCR. Move from SLAM to SUS reporting (requiring additional validations)	ShCR resource paper – additional documentation transfer Establish data quality forum Recruit vacant DQA Assistant role RPA resource paper – additional work to ensure governance	Approved additional resource in principle – awaiting funding Vacancy freeze Audit programme recommenced with weekly patient demographic outpatient audits.

		External issues with ShCR process (increasing volumes of rejections) Volume of pended outpatient appoints requiring review / documenting	around the use of RPA processes.	
2175	Transfer of clinical documentation via Shared Care Record system (12)	Volume of documents transferred via ShCR high. Additional pressure on DQA team to action rejections. Ongoing issues with failed deliveries due 3 rd party supplier systems.	Extend Demographic audits include ED patients. Implement Spine tracing for patients on Harris Flex Review volume of documents and % rejections to assure not increased issue Replace current IHDIs with a direct file from Flex	ED audits commenced Spine trace request submitted. Standing item on bi- weekly applications call with Harris team.

External Data Quality Assurance Monitoring

Elective Recovery - Waiting List National Minimum Dataset

As part of the elective recovery drive all acute trusts were mandated to provide a weekly record level waiting list extract covering referral to treatment, diagnostic and planned/surveillance care. The dataset is a mandated requirement for organisations and has been approved by the NHS Digital Data Standards Board. The data is being used to better understand and manage the waiting list position It is expected that the WLMDS submissions will become the main source of reported waiting time performance data for Trusts with the phasing out of aggregated returns. The information within the WLMDS will also be used to populate waiting time information displayed in the My Planned Care Platform.

Nationally a Data Quality Reporting tool (LUNA) has been developed to support Trusts in making improvements to the quality and consistency of the datasets. Organisations submissions are assessed against 20 key data quality standards and assigned an overall data confidence level. The current week position for the Trust is shown below. The Trust confidence level score of 99.55% is above the national target of 95%, with the weekly trend showing sustained compliance and improvement. Of the total pathways submitted just 3.94% of records have been identified with a data quality flag that may warrant further review. Actions are ongoing to further improve the completeness and validity of submissions. Data quality issues relate to potential duplicate pathways, ED referrals that do not require a pathway.

Current Week – Confidence Level



Confidence Level Trend

	06/09/2026	30/08/2026	23/08/2026	16/08/2026	09/08/2026	02/08/2026	26/07/2026	19/07/2026	12/07/2026
RTT PTL Confidence Level	99.55%	99.47%	99.47%	99.50%	99.51%	99.54%	99.54%	99.51%	99.52%

Data Quality Maturity Index (DQMI)

The DQMI is a monthly national publication intended to raise the profile of data quality in the NHS by providing data submitters with timely and transparent information in relation to the quality of key data submissions. The DQMI scores are based on the completeness, validity, coverage and use of default values within core data items held within key datasets submitted nationally by the Trust to the Secondary Uses Service. Data items monitored include NHS number, date of birth, gender, postcode, speciality and consultant as well as dataset specific items. Overall and dataset specific scores for the Trust are shown below for the period to end May 2026. Scores for all datasets are extremely positive showing a consistently high-performance score during 2026/27 compared to other NHS Trusts. The Trust performs at well above the national average for each key dataset.

	Emergency Care Dataset	Admitted Care Dataset	Outpatient Dataset
National Average	80.3	90.4	84.5
Lancashire Teaching	86.8	99.4	98.8

Scores by individual data items within each dataset are shown in Appendix 1. The summary position shown below indicates a consistent compliance score with 5 fields worse than the national average, a consistent position compared to the previous bi-annual report.

Dataset	Key Fields	Compliant Fields	Var	% Compliance
OP	14	14	0	100.00%
APC	22	22	0	100.00%
ECDS	31	26	-5	83.87%
Total	67	62	-5	92.54%

Plans in place to implement further improvements to the content of the ECDS data flow now that the nationally mandated requirement to submit daily ECDS has been implemented.

Clinical Coding Completeness

The Clinical Coding Team continues to ensure the availability of comprehensively coded data in line with the national flex and freeze timetable. During 2025/26, the Trust maintained a coding completeness level at freeze of 100%. However, the level of coding completeness at flex has dipped slightly to between 70 - 80% due to an increase in the number of episodes to code and complexity of documentation. Clinical Coding teams across OneLSC have developed a pressures paper detailing the key challenges to maintaining the current flex and freeze positions.

For 2026/27 further impacts of increased activity, vacancies and difficulties in recruitment have caused a drop in the achievement of freeze to 85 - 90% and flex to 55 - 60%. This is being addressed with a move towards engaging contract coders.

The Coding Team Business Plan sets out the overall strategy for the future development of the Coding Service incorporating:

- A programme of clinical engagement to enhance quality and depth of coding
- Wider programme of internal audit to enhance coder skill sets including the appointment of a dedicated Audit & Quality Manager to drive quality improvements within the Clinical Coding team
- Fully implemented an enhanced End Coder system that supports additional quality and consistency checks. The upgrade of 3M Medicode system to Medicode 360 has provided additional audit and consistency capability. The upgrade to the system and implementation of OPCS Procedure codes V4.11 has now taken place.

- Engaged with IQVIA to implement their Clinical Coding Analytics tool plus 12 days consultancy during from Oct 2024 to identify opportunities to enhance the depth of admitted care clinical coding. Work is ongoing to action monthly opportunity reports provided by IQVIA.

Recommendations

The Board is asked to note current Data Quality Assurance activities, internal and external monitoring processes and the on-going developments that support further improvements to data quality assurance and data quality engagement

Appendix 1 –DQMI Dataset Compliance

Trust coverage compared to the national average for key data items for the period to May 2026. This is a coverage dashboard not a check of the accuracy of content.

Data Item	Trust May 26	National Average	Variance	Rating	Actions
OUTPATIENT KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	98.9	94.7	4.2		
ADMINISTRATIVE CATEGORY CODE	100	91.2	8.8		
CARE PROFESSIONAL MAIN SPECIALTY CODE	98.9	94	4.9		
CONSULTANT CODE	98.9	77.7	21.2		
ETHNIC CATEGORY	92.3	74.2	18.1		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100	88	12		
NHS NUMBER	100	86.8	13.2		
NHS NUMBER STATUS INDICATOR CODE	100	96	4		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.8	94.4	5.4		
PERSON BIRTH DATE	100	94.3	5.7		
PERSON GENDER CODE CURRENT	100	95.3	4.7		
POSTCODE OF USUAL ADDRESS	99.9	87.6	12.3		
SITE CODE (OF TREATMENT)	100	77.6	22.4		
SOURCE OF REFERRAL FOR OUTPATIENTS	94.3	80.2	14.1		
ADMITTED CARE KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	100	95.9	4.1		
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	100	96	4		
ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	100	96.5	3.5		
CARE PROFESSIONAL MAIN SPECIALTY CODE	100	95.4	4.6		
CONSULTANT CODE	100	89.3	10.7		
DECIDED TO ADMIT DATE	99.9	63.9	36		
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	100	97.3	2.7		
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	100	95.8	4.2		
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	100	95.4	4.6		
ETHNIC CATEGORY	91.2	86.9	4.3		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100	94.7	5.3		
NHS NUMBER	99.9	91.7	8.2		
NHS NUMBER STATUS INDICATOR CODE	100	97.5	2.5		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.6	95.5	4.1		
ORGANISATION CODE (CODE OF PROVIDER)	100	95.3	4.7		
PATIENT CLASSIFICATION CODE	100	97.5	2.5		
PERSON BIRTH DATE	100	96.9	3.1		
PERSON GENDER CODE CURRENT	100	97.1	2.9		
POSTCODE OF USUAL ADDRESS	99.8	93.8	6		

PRIMARY DIAGNOSIS (ICD)	96.5	87.3	9.2	
SITE CODE (OF TREATMENT)	100	84.6	15.4	
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	100	96.4	3.6	
EMERGENCY CARE DATASET KEY DATA ITEMS				
ACUITY (SNOMED CT)	99.8	84.4	15.4	
ARRIVAL DATE	100	98.8	1.2	
ARRIVAL MODE (SNOMED CT)	99.9	92	7.9	
ARRIVAL TIME	99.4	95.5	3.9	
ATTENDANCE CATEGORY	100	87.9	12.1	
ATTENDANCE SOURCE (SNOMED CT)	18.1	65.3	-47.2	
CHIEF COMPLAINT (SNOMED CT)	85.4	67.4	18	
CLINICAL INVESTIGATION (SNOMED CT) - FIRST	45.5	68.9	-23.4	
CLINICALLY READY TO PROCEED	78.3	52.5	25.8	
DATE SEEN FOR TREATMENT	98.9	81.7	17.2	
DEPARTURE DATE	99.1	94.7	4.4	
DEPARTURE TIME	99.9	94.9	5	
DIAGNOSIS (SNOMED CT) - FIRST	71.4	61.3	10.1	
DISCHARGE DESTINATION (SNOMED CT)	99.6	85	14.6	
DISCHARGE FOLLOW-UP (SNOMED CT)	98.4	70.4	28	
DISCHARGE STATUS (SNOMED CT)	99.6	86.6	13	
ETHNIC CATEGORY	98	85.8	12.2	
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.9	96.9	3	
INITIAL ASSESSMENT DATE	99.9	81.8	18.1	
INITIAL ASSESSMENT TIME	99.2	79	20.2	
INJURY INTENT (SNOMED CT)	8.9	37.6	-28.7	
NHS NUMBER	99.5	96	3.5	
NHS NUMBER STATUS INDICATOR CODE	99.8	98.7	1.1	
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	98.4	91.8	6.6	
PERSON BIRTH DATE	100	96.2	3.8	
PERSON STATED GENDER CODE	100	96.3	3.7	
POSTCODE OF USUAL ADDRESS	99.6	96.7	2.9	
PROCEDURE (SNOMED CT) - FIRST	99.6	71.5	28.1	
PROCEDURE DATE - FIRST	45.5	63	-17.5	
PROCEDURE TIME - FIRST	44.1	46.2	-2.1	
TIME SEEN FOR TREATMENT	98.3	78.2	20.1	

14.2 CORPORATE CALENDAR 2027-28

● Information Item

REFERENCES

Only PDFs are attached

 14.2 Corporate and Governor Calendar 2027-28 Ancillary BoD Pt I Oct 2026.pdf

Please do not print!



Corporate and Governors' Calendar 2027-28

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

BOARD OF DIRECTORS AND COMMITTEES OF THE BOARD:

- Audit Committee
- Board of Directors
- Board Workshops
- Charitable Funds Committee
- Finance and Performance Committee
- Non-Executive Directors' meetings
- People and Partnerships Committee
- Remuneration Committee
- Safety and Quality Committee
- Board Strategy Away Day

COUNCIL OF GOVERNORS, SUBGROUPS, AND MISCELLANEOUS MEETINGS:

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

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Annual Members' Meeting	22

2027-28 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 2027		
06	1.00pm – 3.00pm	Council Training Session
08	9.15am – 3.00pm	Board of Directors
15	10.00am – 11.30am	Nominations Committee
15	10.30am – 1.00pm	Audit Committee
22	1.00pm – 4.00pm	Council of Governors
27	1.00pm – 4.00pm	Finance and Performance Committee
29	2.00pm – 3.30pm	Remuneration Committee
30	11.00am – 1.30pm	Safety and Quality Committee

MAY 2027		
04	1.00pm – 3.30pm	Board Workshop
10	10.00am – 12.30pm	Care and Safety Subgroup
11	10.00am – 11.30am	Membership Subgroup
11	1.00pm – 4.00pm	People and Partnerships Committee
13	1.00pm – 3.00pm	Council Training Session
20	1.00pm – 3.00pm	Joint Board and Governor Development Session
25	1.00pm – 4.00pm	Finance and Performance Committee
28	11.00am – 1.30pm	Safety and Quality Committee

JUNE 2027		
03	9.15am – 3.00pm	Board of Directors
15	1.00pm – 2.30pm	Charitable Funds Committee
17	10.30am – 1.00pm	Audit Committee
22	1.00pm – 4.00pm	Finance and Performance Committee
25	11.00am – 1.30pm	Safety and Quality Committee

JULY 2027		
13	1.00pm – 4.00pm	People and Partnerships Committee
15	12.30pm – 3.00pm	Care and Safety Subgroup
22	10.00am – 1.00pm	Council of Governors
27	1.00pm – 4.00pm	Finance and Performance Committee
29	1.00pm – 3.30pm	Board Workshop
30	11.00am – 1.30pm	Safety and Quality Committee

AUGUST 2027		
05	9.15am – 3.00pm	Board of Directors
13	10.00am – 11.30am	Membership Subgroup
19	1.00pm – 3.00pm	Council Training Session
24	1.00pm – 4.00pm	Finance and Performance Committee
27	11.00am – 1.30pm	Safety and Quality Committee

SEPTEMBER 2027		
07	1.00pm – 3.30pm	Board Workshop
08	10.00am – 12.30pm	Care and Safety Subgroup
09	11.00am – 12.30pm	Remuneration Committee
14	1.00pm – 4.00pm	People and Partnerships Committee
14	9.30am – 11.00am	Charitable Funds Committee
16	10.30am – 1.00pm	Audit Committee
23	1.00pm – 3.00pm	Joint Board and Council Development Session
24	11.00am – 1.30pm	Safety and Quality Committee
28	1.00pm – 4.00pm	Finance and Performance Committee

OCTOBER 2027		
07	9.15am – 3.00pm	Board of Directors
07	2.00pm – 4.00pm	Annual Members' Meeting
14	10.00am – 12.00pm	Council Training Session
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

NOVEMBER 2027		
09	1.00pm – 4.00pm	People and Partnerships Committee
11	1.00pm – 3.00pm	Board Workshop
15	12.30pm – 3.00pm	Care and Safety Subgroup
16	11.30am – 1.00pm	Membership Subgroup
23	1.00pm – 4.00pm	Finance and Performance Committee
26	11.00am – 1.30pm	Safety and Quality Committee

DECEMBER 2027		
02	9.15am – 3.00pm	Board of Directors
14	1.00pm – 2.30pm	Charitable Funds Committee
16	1.00pm – 3.00pm	Council Training Session
21	1.00pm – 4.00pm	Finance and Performance Committee

JANUARY 2028		
07	11.00am – 1.30pm	Safety and Quality Committee
11	1.00pm – 4.00pm	People and Partnerships Committee
13	10.30am – 1.00pm	Audit Committee
17	10.00am – 12.30pm	Care and Safety Subgroup
20	10.00am – 1.00pm	Council of Governors
25	1.00pm – 4.00pm	Finance and Performance Committee
27	1.00pm – 3.30pm	Board Workshop
28	11.00am – 1.30pm	Safety and Quality Committee

FEBRUARY 2028		
03	9.15am – 3.00pm	Board of Directors
10	10.00am – 12.00pm	Council Training Session
11	10.00am – 11.30am	Membership Subgroup
22	1.00pm – 4.00pm	Finance and Performance Committee
25	11.00am – 1.30pm	Safety and Quality Committee

MARCH 2028		
02	1.00pm – 3.30pm	Board Workshop
09	12.30pm – 3.00pm	Care and Safety Subgroup
14	1.00pm – 4.00pm	People and Partnerships Committee
14	9.30am – 11.00am	Charitable Funds Committee
28	1.00pm – 4.00pm	Finance and Performance Committee
31	11.00am – 1.30pm	Safety and Quality Committee

Audit Committee

Date	Time	Venue	Final date for receipt of reports:
15/04/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	08/04/2027
17/06/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	10/06/2027
16/09/2027	10.30am – 1.00pm	Virtually using Microsoft Teams	09/09/2027
13/01/2028	10.30am – 1.00pm	Virtually using Microsoft Teams	06/01/2028

Members	In attendance
Four Non-Executive Directors: - Audit Committee Chair - Finance and Performance Committee Chair - Safety and Quality 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:
08/04/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	31/03/2027
03/06/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/05/2027
05/08/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	28/07/2027
07/10/2027	9.15am – 3.00pm	Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital	29/09/2027
02/12/2027	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	24/11/2026
03/02/2028	9.15am – 3.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/01/2028

Members	In attendance
Chair Non-Executive Directors Chief Officers	Chief People Officer Chief Strategy and Improvement Officer Director of Communications and Engagement Director of Corporate Affairs Business Manager (minutes)

Board Strategy Away Day

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

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

Board Workshop

Date	Time	Venue	Final date for receipt of reports:
04/05/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	27/04/2027
29/07/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	22/07/2027
07/09/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	31/08/2027
11/11/2027	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	04/11/2027
27/01/2028	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	20/01/2028
02/03/2028	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	24/02/2028

Members	In attendance
Chair Non-Executive Directors Chief Officers	Chief People Officer Chief Strategy and Improvement Officer 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:
15/06/2027	1.00pm - 2.30pm	Virtually using Microsoft Teams	08/06/2027
14/09/2027	9.30am – 11.00am	Virtually using Microsoft Teams	07/09/2027
14/12/2027	1.00pm - 2.30pm	Virtually using Microsoft Teams	07/12/2027
14/03/2028	9.30am – 11.00am	Virtually using Microsoft Teams	07/03/2028

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

Finance and Performance Committee

Date	Time	Venue	Final date for receipt of reports:
27/04/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	20/04/2027
25/05/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	18/05/2027
22/06/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	15/06/2027
27/07/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	20/07/2027
24/08/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	17/08/2027
28/09/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	21/09/2027
26/10/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	19/10/2027
23/11/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	16/11/2027
21/12/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	14/12/2027
25/01/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	18/01/2028
22/02/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	15/02/2028
28/03/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	21/03/2028

Members	In attendance
Four Non-Executive Directors comprising: - Committee Chair - Three Non-Executive Directors Chief Operating Officer Chief Finance Officer Chief Strategy and Improvement Officer	Chief Medical Officer Chief People Officer 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
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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

People and Partnerships Committee

Date	Time	Venue	Final date for receipt of reports:
11/05/2027	1.00pm – 4.00pm	Virtually using Microsoft Teams	04/05/2027
13/07/2027	1.00pm – 4.00pm	Virtually using Microsoft Teams	06/07/2027
14/09/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	07/09/2027
09/11/2027	1.00pm - 4.00pm	Virtually using Microsoft Teams	02/11/2027
11/01/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	04/01/2028
14/03/2028	1.00pm - 4.00pm	Virtually using Microsoft Teams	07/03/2028

Members	In attendance
Four Non-Executive Directors comprising: - Committee Chair - Three Non-Executive Directors Chief People Officer Chief Medical Officer Director of Communications and Engagement	Deputy Chief People Officer Associate Director of Workforce Deputy Director of Education Deputy Director of Research and Innovation Associate Director of Risk and Assurance Director of Corporate Affairs Corporate Affairs Officer (minutes)

Remuneration Committee

Date	Time	Venue	Final date for receipt of reports:
29/04/2027	2.00pm – 3.30pm	Virtually using Microsoft Teams	22/04/2027
09/09/2027	11.00am – 12.30pm	Virtually using Microsoft Teams	02/09/2027

Members	In attendance
Chair Non-Executive Directors	Chief Executive Officer Chief People Officer Director of Corporate Affairs Business Manager (minutes)

Safety and Quality Committee

Date	Time	Venue	Final date for receipt of reports:
30/04/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	23/04/2027
28/05/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	21/05/2027
25/06/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	18/06/2027
30/07/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	23/07/2027
27/08/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	20/08/2027
24/09/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	17/09/2027
29/10/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	22/10/2027
26/11/2027	11.00am – 1.30pm	Virtually using Microsoft Teams	19/11/2027
07/01/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	31/12/2027
28/01/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	21/01/2028
25/02/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	18/02/2028
31/03/2028	11.00am – 1.30pm	Virtually using Microsoft Teams	24/03/2028

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

Care and Safety Subgroup *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
10/05/2027	10.00am - 12.30pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	03/05/2027
15/07/2027	12.30pm - 3:00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	08/07/2027
08/09/2027	10.00am - 12.30pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	01/09/2027
15/11/2027	12.30pm - 3:00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	08/11/2027
17/01/2028	10.00am - 12.30pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	10/01/2028
09/03/2028	12.30pm - 3:00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	02/03/2028

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)

Council Training Sessions *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
06/04/2027	1.00pm – 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	30/03/2027
13/05/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	06/05/2027
19/08/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	12/08/2027
14/10/2027	10.00am - 12.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	07/10/2027
16/12/2027	1.00pm - 3.00pm	Seminar Room A, Education Centre 3, Chorley & South Ribble Hospital	09/12/2027
10/02/2028	10.00am-12.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	03/02/2028

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

Council of Governors *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
22/04/2027	1:00pm - 4:00pm	Seminar Room A, Education Centre 3, Chorley & South Ribble Hospital	15/04/2027
22/07/2027	10.00am - 1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	15/07/2027
21/10/2027	1:00pm - 4:00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	14/10/2027
20/01/2028	10.00am - 1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	13/01/2028

Members	In attendance
Chair Governors	Chief Executive Officer Non-Executive Directors Director of Corporate Affairs Business Manager (minutes)

Membership Subgroup *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
11/05/2027	10.00am – 11.30am	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	04/05/2027
13/08/2027	10.00am – 11.30am	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	06/08/2027
16/11/2027	11.30am – 1.00pm	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	09/11/2027
11/02/2028	10.00am – 11.30am	Hybrid Meeting – Gordon Hesling Conference Room, Royal Preston Hospital	04/02/2028

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

Nominations Committee *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
15/04/2027	10.00am – 11.30am	Virtually using Microsoft Teams	08/04/2027

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

Joint Board and Council Development Session *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue	Final date for receipt of reports:
20/05/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	13/05/2027
23/09/2027	1.00pm - 3.00pm	Lecture Room 3, Education Centre 1, Royal Preston Hospital	16/09/2027

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

Annual Members’ Meeting *To be confirmed, subject to any future statutory requirements*

Date	Time	Venue
07/10/2026	2.00pm – 4.00pm	To be confirmed

Members	In attendance
Chair Non-Executive Directors Chief Officers Chief Strategy and Improvement Officer Director of Communications and Engagement	Communications Team Director of Corporate Affairs Business Manager Corporate Affairs Officers
<i>All other staff welcome to attend</i>	

14.3 MATERNITY AND NEONATAL SERVICES BASELINE ASSESSMENT AGAINST THE 10-POINT PLAN

● Information Item

REFERENCES

Only PDFs are attached



14.3 Maternity Specific Triage Benchmarking Audit Full Ancillary Board Pt I October 2026.pdf



14.3 Maternity & Neonatal Services Baseline Assessment 10-Point Plan Full Ancillary Board Pt I October 2026.pdf



14.3 MOSS Drill Report Ancillary Board Pt I October 2026.pdf



Board of Directors

Meeting of the	Board of Directors	01.10.2026	
Title of Report	Maternity Specific Triage Benchmarking Audit		
Report Author	Emma Ashton– Divisional Midwifery & Nursing Director		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board of Directors are asked to: i. Approve the self-assessment against the triage standards, noting that the financial implications are currently estimates and remain subject to NHS England funding allocation and the Trust’s internal financial governance and planning processes.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	The maternity service has completed the Maternity Triage Specification Benchmarking Audit Tool to benchmark its maternity triage service against the national Maternity Triage Specification. This is a nationally requested audit which requires approval by the Trust Board and submission to NHS England by Friday 25th September 2026. The assessment demonstrates a service with several established strengths in governance, urgent care recognition, access pathways, and clinical escalation processes, but identifies significant improvement requirements in estates and facilities, workforce capability, telephone triage, equity, training, and data utilisation. The review found that most standards are either fully in place or partially in place, with relatively few areas assessed as completely absent. However, many standards remain partially implemented and require further evidence, standardisation, or embedding into routine practice. Key challenges relate to infrastructure, workforce capacity, training frameworks, and the development of a modern maternity triage model aligned with national guidance The service demonstrated strong performance in several areas: • Maternity triage is recognised as the primary urgent and emergency access point for pregnant and postnatal women. • Established 24/7 access arrangements and referral pathways are largely in place. • Open-access arrangements ensure women can attend without referral or appointment. • Effective escalation processes and participation in wider maternity networks support safe care delivery. • Diagnostic facilities are available within the service. • Governance structures, incident review processes and PSIRF arrangements are well established. • Collaboration with the Maternity and Neonatal Voices Partnership (MNVP) is embedded. • Data collection is established for many key activity and performance indicators. Key Areas Requiring Improvement were highlighted as: 1. Estates and Environment (Highest Priority)		

The largest gap identified relates to the physical maternity triage environment:

- The current triage area is not co-located with labour ward services.
- There is no dedicated waiting area.
- Initial triage assessment space is not protected or purpose designed.
- Privacy and confidentiality are compromised by the current layout.
- Office accommodation is not at the required standard to deliver triage standards.
- Signage and accessibility require improvement.
- The environment does not fully support women's comfort, safety and reassurance.

An estimated £4 million capital investment may be required to address infrastructure deficiencies and deliver a fit-for-purpose maternity triage environment.

2. Workforce and Training

Workforce-related improvements are required:

- Vacant posts require recruitment.
- Dedicated maternity triage competencies are not fully established.
- A specific maternity triage training programme requires development.
- Staff training in triage methodology, equality, cultural competence and unconscious bias needs strengthening.
- Consultant oversight and formalised ward-round arrangements require further definition.
- Staffing models require further alignment with national guidance and the BSOTS model.

Estimated costs include approximately £150,000 for administrative support

3. Telephone Triage

Telephone triage was identified as a priority area for development:

- A fully integrated single point of access has not yet been embedded.
- No dedicated, protected telephone triage space exists.
- Telephone triage policies require strengthening.
- Preterm labour pathways need clearer system-wide agreement.
- Call recording functionality is not available.

Estimated costs include approximately £20,790 implementation costs plus £15,084 annual licensing costs for telephone recording solutions. Total estimated investment identified under Principle 5 is £35,874.

4. Equality, Diversity and Inclusion

The assessment highlights opportunities to improve equitable access:

- Translation services and communication support require stronger operational embedding.
- Accessible formats and multilingual resources need wider availability.
- Analysis of inequalities by ethnicity, language and deprivation requires development.
- Staff training on cultural competence and health inequalities requires strengthening.

5. Data and Measurement

Although extensive data is collected, the service lacks:

- A dedicated maternity triage dashboard.
- Formal reporting schedules.
- Comprehensive measurement of all specification metrics.
- Consistent monitoring of inequalities data.
- Structured approaches for reviewing performance trends and improvement actions.

Total identified estimated costs currently exceed **£4.235,874 million**, with additional investment requirements possible following detailed estates and digital reviews.

The summary position as per submitted is detailed below.

	Maternity Triage Specification Benchmarking Audit Tool Dashboard Click below to link through to each principle <table><tr><td>Principle 1: Access and integration</td><td>Clear, local 24/7 pathways so women know where to go and are supported between services.</td><td>45%</td><td>55%</td><td>0%</td><td>0%</td><td>0%</td><td>£0.00</td></tr><tr><td>Principle 2: Recognition as urgent care</td><td>Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.</td><td>40%</td><td>60%</td><td>0%</td><td>0%</td><td>0%</td><td>£50,000.00</td></tr><tr><td>Principle 3: Assessment and care of women</td><td>Every woman receives timely assessment, prioritisation and a clear plan of care.</td><td>20%</td><td>60%</td><td>20%</td><td>0%</td><td>0%</td><td>£0.00</td></tr><tr><td>Principle 4: Clear information for women</td><td>Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.</td><td>33%</td><td>67%</td><td>0%</td><td>0%</td><td>0%</td><td>£0.00</td></tr><tr><td>Principle 5: Telephone maternity triage</td><td>A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.</td><td>13%</td><td>50%</td><td>38%</td><td>0%</td><td>0%</td><td>£35,874.00</td></tr><tr><td>Principle 6: Service user voice and experience</td><td>Women's feedback must shape service design, improvement and experience.</td><td>20%</td><td>60%</td><td>20%</td><td>0%</td><td>0%</td><td>£0.00</td></tr><tr><td>Principle 7: Facilities and estates</td><td>Triage needs safe, visible, fit-for-purpose space designed for urgent care.</td><td>10%</td><td>50%</td><td>40%</td><td>0%</td><td>0%</td><td>£4,000,000.00</td></tr><tr><td>Principle 8: Staffing</td><td>Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.</td><td>8%</td><td>83%</td><td>8%</td><td>0%</td><td>0%</td><td>£150,000.00</td></tr><tr><td>Principle 9: Equity and equality</td><td>Services must use data and targeted action to identify and reduce inequalities.</td><td>20%</td><td>60%</td><td>20%</td><td>0%</td><td>0%</td><td>£0.00</td></tr><tr><td>Principle 10: Data and measurement</td><td>Data must drive oversight, learning from incidents and continuous improvement.</td><td>14%</td><td>86%</td><td>0%</td><td>0%</td><td>0%</td><td>£0.00</td></tr></table>	Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	45%	55%	0%	0%	0%	£0.00	Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	40%	60%	0%	0%	0%	£50,000.00	Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	20%	60%	20%	0%	0%	£0.00	Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	67%	0%	0%	0%	£0.00	Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	13%	50%	38%	0%	0%	£35,874.00	Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	60%	20%	0%	0%	£0.00	Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	10%	50%	40%	0%	0%	£4,000,000.00	Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	8%	83%	8%	0%	0%	£150,000.00	Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	20%	60%	20%	0%	0%	£0.00	Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	14%	86%	0%	0%	0%	£0.00	
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Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	14%	86%	0%	0%	0%	£0.00																																																																											
	The maternity triage service demonstrates a strong commitment to safe and responsive urgent maternity care and has many foundational elements already established. However, focused improvement work is required to achieve full compliance with the Maternity Triage Specification. The most substantial risks relate to estate limitations, workforce capability, training, telephone triage arrangements, and the need for more robust measurement and equity-focused improvements. Successful delivery will require sustained Board oversight, investment in infrastructure and workforce, and a structured improvement programme aligned to national guidance.																																																																																	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒																																																																																
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒																																																																																
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒																																																																																
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒																																																																																
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒																																																																																
Due Diligence	To give the Trust Board assurance, please complete the following:																																																																																	
Committee Approval:	NA	NA																																																																																
Operational Group Review:	Divisional Safety and Quality	Date: 23 September 2026																																																																																
Link to Board Assurance Framework:	PR1 – Patient Safety and Experience within the Urgent and Emergency Care Pathway PR2 – People Experiencing Health Inequalities PR7 – Experience of Under-Represented Staff Groups PR8 – Experience of Staff and Levels of Staff Satisfaction																																																																																	
Appendices	Ancillary Report 1 Maternity Triage Specification Benchmarking Audit Tool																																																																																	

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

Lancashire Teaching Hospitals NHS Foundation Trust

Please enter the **trust site** below:

Sharoe Green Unit, Royal Preston Hospital

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:

Fully in place, evidenced and embedded

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:

Site captures this data

Site partially captures this data

Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:

Site partially captures this data

Site doesn't capture this data

There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification Benchmarking Audit Tool Dashboard

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		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: <u>Access and integration</u>	Clear, local 24/7 pathways so women know where to go and are supported between services.	45%	55%	0%	0%	0%	£0.00
Principle 2: <u>Recognition as urgent care</u>	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	40%	60%	0%	0%	0%	£50,000.00
Principle 3: <u>Assessment and care of women</u>	Every woman receives timely assessment, prioritisation and a clear plan of care.	20%	60%	20%	0%	0%	£0.00
Principle 4: <u>Clear information for women</u>	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	67%	0%	0%	0%	£0.00
Principle 5: <u>Telephone maternity triage</u>	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	13%	50%	38%	0%	0%	£35,874.00
Principle 6: <u>Service user voice and experience</u>	Women's feedback must shape service design, improvement and experience.	20%	60%	20%	0%	0%	£0.00
Principle 7: <u>Facilities and estates</u>	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	10%	50%	40%	0%	0%	£4,000,000.00
Principle 8: <u>Staffing</u>	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	8%	83%	8%	0%	0%	£150,000.00
Principle 9: <u>Equity and equality</u>	Services must use data and targeted action to identify and reduce inequalities.	20%	60%	20%	0%	0%	£0.00
Principle 10: <u>Data and measurement</u>	Data must drive oversight, learning from incidents and continuous improvement.	14%	86%	0%	0%	0%	£0.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance										
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Fully in place, embedded and evidenced	No further action required										
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Fully in place, embedded and evidenced	No further action required										
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3. Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Develop a documented system wide agreement, led by LTH under the workstream of the maternity care bundle for pre-hospital care. 2. NHS 111 and Primary care representatives to be included in the guideline for review and comments.										
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for all women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Results of the translation audit to be embedded in Maternity annual training, to strengthen the message of the importance of using professional translation services, to ensure that assessment are not compromised by language barriers and to understand about communication related bias. 2. The use of professional translation services should be included in SOP-190 for Maternity triage. 3. Strengthen visibility of maternity triage on the Trust website for Maternity Assessment Suite (MAS) (MAS manager with website lead). Check that easy to read and translatable versions of patient information are available on BadgerNet (IT midwife). 4. To develop open access cards that can be given to non- English speaking women in appropriate language during early bird session/ community midwife booking advising women to self present at MAS if any pregnancy related concerns 5. Review triage pathways to reduce any barriers to access										
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Strengthen signage and information about access routes to the Maternity Assessment Suite										

	4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Information is not fully evidenced		
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Fully in place, embedded and evidenced	No further action required	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Matron and MAS manager to add MAS referral criteria into relevant SOP and to explore if the community midwifery/ antenatal care guidelines need to be updated.	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Fully in place, embedded and evidenced	No further action required	
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Fully in place, embedded and evidenced	No further action required	
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. SOP to be strengthened to include the discharge process and follow up information given to women when being discharged from MAS / Maternity triage 2. Explore how summary of care can be shared with GP from the digital system and compliance monitored and reported	
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or paediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or paediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. SOP to be strengthened to include the assessment, treatment, discharge process and follow up information given to women when being discharged from MAS / Maternity triage .as well as care for the baby.Prevention of separation of mother and baby should be outlined and security of the baby 2. Add line in SOP re referral to Paediatric Assessment Unit. Change 4 weeks to 6 weeks re access	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site captures this data	No further action required		£0.00

Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site captures this data	No further action required
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site captures this data	No further action required
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site Partially captures this data	A Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Explore how this can be captured consistently

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Principle 2: Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	specification standard
Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.	1. Maternity triage is formally recognised within organisational policies and governance structures as a safety-critical clinical environment. 2. Maternity triage is recognised as the primary access point for urgent and emergency maternity advice, assessment and care. 3. Pathways are in place clearly identifying maternity triage as the preferred point of access for women with urgent pregnancy, labour or postnatal concerns up to six weeks.	Fully in place, embedded and evidenced	No further action required	
Design maternity triage to provide rapid assessment and care, ensuring every woman receives initial triage assessment within 15 minutes of arrival regardless of time of day or service pressures.	1. A Local standard is in place requiring all women attending maternity triage receives an initial assessment within 15 minutes of arrival. 2. The service has systems in place to monitor compliance to the 15 minutes from arrival assessment. 3. The service has systems in place to monitor compliance of the 15 minutes assessment regardless of route of presentation, clinical condition, time of day, day of week or service pressures. 4. Clear guidance exists defining the minimum requirements for the initial triage assessment 5. Workforce contingency plans are in place to achieve the 15 minutes assessment, including at times of peak demand. 6. Escalation processes are in place for when timely assessment is threatened due to increased acuity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Recruitment at all vacant posts to effectively run BSOTS and review staffing model 2. Strengthen escalation processes and explore MAS specific acuity tool	
Ensure maternity triage is accessible to all women presenting with unscheduled pregnancy, labour or postpartum concerns without requiring an appointment or referral.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Fully in place, embedded and evidenced	No further action required	
Embed a culture that validates and responds to women's concerns, reinforcing that seeking care was the right decision and that accessing triage is appropriate whenever women have concerns.	1. The service promotes a culture where women's concerns are listened to, taken seriously and responded to appropriately 2. The service actively promotes staff consistently reassuring women that seeking advice or assessment was appropriate, regardless of the outcome of assessment. 3. Women can report through patient experience options experience of maternity triage services. 4. . Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Fully in place, embedded and evidenced	No further action required	
Provide information on expected waiting times based on risk categorisation on arrival, including real-time updates where feasible.	1. The service has defined waiting time expectations aligned to their local triage risk categorisation. 2. Systems are in place to ensure women are informed and updated regarding delays and waiting times where feasible.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. To develop care catagory cards to be given to women following initial triage, explaining BSOTS grading and on going care time parameters.	
Operate as a safety net with an open-door approach: women can attend in-person maternity triage without prior contact: attendance is accented without	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral.		No further action required	

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Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. SOP-190 to be updated to ensure all RCOG items are embedded and reflected in SOP	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. MAS manager and Practice educator to update the TNA EBG0091 and develop a specific training programme exclusively for maternity triage (MAS) maternity staff. This should be reviewed on an annual basis	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Fully implement the BSOTS model of care as barriers are resolved through the implementation of the national framework	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Fully in place, embedded and evidenced	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Maternity training to be focused on the importance of acknowledging and understanding inequalities, use a reflective patient experience in MAS when accessing care via Maternity triage (practice Educator) 2. MAS manager, lead obstetrician and Practice educator to update the TNA EBG0091 3. Participate in National Equality and Anti Discrimination programme ☐ ☐ ☐	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site captures this data	Please outline what support you require from your trust board below	£0.00

Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	Please outline what support you require from your trust board below
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded. Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.	Site Partially captures this data	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Due to current working model all ongoing care is provided immediately following assessment, delays in first assessment captured. <u>Care pathway in department needs to be changed to reflect BSOTS care pathway recommendations</u>
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care. Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.	Site captures this data	Please outline what support you require from your trust board below Captured via local data and incident reporting

Principle 4: Clear information for women Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.			Principles menu Previous 1 2 3 5 6 7 8 9 10 Next										Estimated cost to progress compliance of specification standard
Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance										
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Strengthen visibility of maternity triage on the Trust website for MAS (MAS Manager with website lead)										
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Strengthen visibility of maternity triage on the Trust website for MAS (MAS Manager with website lead) 2. Check that easy to read and translatable versions of patient information are available on BadgerNet (IT midwife)										
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Results of the translation audit to be embedded in Maternity annual training, to strengthen the message of the importance of using professional translation services, to ensure that assessment are not compromised by language barriers and to understand about communication related bias. 2. The use of professional translation services should be included in SOP-190 for Maternity triage										
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Process for discharge to be updated in the SOP-190 that includes includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. The standardised discharge process should include information about follow-up arrangements, investigations, appointments and ongoing care needs and about contact information with women prior to discharge from MAS/Maternity triage										
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Fully in place, embedded and evidenced	No further action required										
Metrics	Data captured per site									Total estimated cost to implement this principle			
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.	Site captures this data	Please outline what support you require from your trust board below								£0.00			

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	progress compliance of specification standard
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone triage functions are delivered safely, including not diverting to labour ward due to unknown response times.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight 1. Telephone triage to be used by all women, regardless of the intended place of birth. SOP for Midwifery Led Care (MLC) and SOP-190 to reflect consistent guidance that women should only contact the maternity triage if any concerns, when asking for advise or when in labour. 2. Maternity triage staff need to complete training for the use of the single point of access and the single telephone line.	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage compliments not replaces direct care.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of the new pathway and awareness raised with staff and service users. 2. Telephone triage to be used by all women, regardless of the intended place of birth. SOP for MLC and SOP-190 to reflect consistent guidance that women should only contact the maternity triage if any concerns, when asking for advise or when in labour. 3. Maternity triage staff need to complete training for the use of the single point of access and the single telephone line. ☐ ☐ ☐	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Fully in place, embedded and evidenced	No further action required	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below There is not currently an identified specific space for maternity telephone triage within the existing estate. This will be incorporated in the wider estate piece of work and costings provided as a whole solution for this issue. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	This is included in the overall estates estimated costs
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. SOP 190 to be strengthened to reflect this guidance	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage assessment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. SOP to be strengthened to reflect this guidance	
Maintain clear pathways so suspected threatened	1. The service has a documented pathway for the assessment of suspected		Please outline what support you require from your trust board below	

preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for suspected preterm and extremely preterm birth.	Not in place, significant gaps or limited evidence	Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Participate in the development of a documented system wide agreement, under the workstream of the maternity care bundle for pre-hospital care. 2. NHS 111 and Primary care representatives to be included in the guideline for review and comments. 3. Review and update the Maternity Assessment Suite guideline to explicitly state actions when a woman contacts the service in suspected preterm labour	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below There is currently no capability to audio-record calls. The Trust Board is asked to support the exploration of a system whereby calls can be recorded and stored as part of the record and to support the service to explore funding opportunities	Implementation/capital costs = £20,790 Annual licensing = £15,084

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site captures this data	Please outline what support you require from your trust board below	£35,874.00
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Develop a method of recording performance data for this metric	
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site captures this data	Please outline what support you require from your trust board below	

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Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

Specification standard		Benchmarking suggestions in line with the specification	Benchmark Rating	Principles menu											Estimated cost to progress compliance of specification standard
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				Support required from Trust Boards to progress compliance											
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.		1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Continue with ongoing work around the Health inequalities workstream, with clear metrics and timeframes for progress. (Consultant Midwife and CI lead MW) 2. MAS manager to develop a clear pathway where staff working in MAS actively seek feedback from a diverse range of women, listening to their experiences 3. Develop a mechanism to explicitly seek feedback on maternity triage experiences to enable a continuous improvement approach to this.											
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.		1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Engage with MNVP regarding the need for feedback focus groups 2. Document the approach to ensuring feedback is representative from the women and families using the services. 3. Implement close to real time feedback model											
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.		1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Local feedback tool to be developed that can be displayed and explained to service users during attendance 2. Quality Improvement programmes following feedback from experience will be communicated to staff and patients.											
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.		1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Martha's Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. MAS manager, Matron and obstetric lead to strengthen SOP - 190 to reflect Martha's rule and implement fully and align to Trust documents.											
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.		1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Adopt PREM tool once this becomes available nationally											
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.		1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Near real time patient feedback model to be implemented and include specific feedback on maternity triage.											
Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making and service design; close the feedback loop through "you said, we did" updates.		1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)	Fully in place, embedded and evidenced	No further action required											

Total estimated cost to implement this principle

£0.00

Dashboard

Principle 7: Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	progress compliance on specification standard
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Complete a formal risk assessment to ensure delays are minimised in line with this metric	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Women attending Triage currently sit in the clinical area whilst they wait to be seen. This can be problematic when emergencies are occurring. Also an issue with lack of space when triage is busy meaning that women overflow into area used by ultrasound. No separate designated waiting area available at this time and cannot improve unless maternity triage is located to another area. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	£4,000,000.00
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric. In addition the Board will be asked through agreed governance processes to consider the implementation of administrative support in this area, to enable timely admission and discharge processes, to provide a consistent patient facing member of staff to welcome patients, and to support clinical staff with administrative duties thus freeing up clinical capacity	Costing for this will be captured in Principle 8 relating to staffing
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Maternity Triage is currently situated on the ground floor, there is currently no protected space for initial triage. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities in line with accepted governance processes to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	Please see overall estates estimated costing above
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below There is currently no protected space for initial triage. The space and location in maternity triage is limited - there are 2 side rooms which are also used as private examination rooms and then there are 5 chair spaces separated by curtains. The waiting area is limited , the overall environment does not afford sufficient privacy during discussions and treatment, and the space is not sufficient to accommodate the activity appropriately. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities within agreed governance processes to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	Please see overall estates estimated costing above
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of workload.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Small office space situated behind the reception desk in department however this is not of a sufficient size to accommodate all staff working in the area. It is located in a clinical space which does not provide a compliant space for care handovers or telephone triage in line with guidance. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities within agreed governance processes to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	Please see overall estates estimated costing above
Ensure access to essential diagnostics including	1. Maternity triage has timely access to diagnostic investigation equipment.		No further action required	

electronic fetal monitoring, blood tests, urine samples and ultrasound.		Fully in place, embedded and evidenced		
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted. 3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Accessible WC available in the scan department located next to the triage area however this is not clearly signposted. Signposting to maternity triage is not sufficient - this requires strengthening to support all women to access Maternity triage regardless of language capability, disability or accessibility. Information about waiting times and clinical prioritisation is not in place. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities within agreed governance processes to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	Please see overall estates estimated costing above
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity triage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from day assessment, antenatal clinic and other scheduled care areas.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Maternity triage is based on the ground floor in a dedicated area (MAS) however this area is not specifically designed to support maternity triage functions or for urgent/unscheduled care. Maternity triage is separate from the day assessment, which is located in antenatal clinic. However the MAS department currently continue to see a portion of the antenatal planned work. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities within agreed governance processes to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	Please see overall estates estimated costing above
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Maternity triage is based on the ground floor in a dedicated area (MAS) however this area is not specifically designed to support maternity triage functions or for urgent/unscheduled care. The environment can cause challenges for providing women with a sense of safety and reassurance due to the size, facilities and location. The Trust Board is asked to support the progression of estates planning and work and support the service to explore funding opportunities within agreed governance processes to enable the estates work to be undertaken to resolve the issues identified in achieving compliance with this metric.	Please see overall estates estimated costing above
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Maternity triage utilises the trust electronic patient record system together with Badger Net to document admission, discharge and management of clinical care. There are computers available in the maternity triage area to support staff to document in a timely manner. Wider hospital use Flex system for documentation and are unable to access BadgerNet. The Trust Board is asked to support the service to explore digital solutions such as the use of whiteboards to resolve the issues identified in achieving compliance with this metric* Note estimated costs included at this time)	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user experience.	Site Partially captures this data	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Improve transfer data quality to show accurate times for transfer from one department to another.		£4,000,000.00

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Principle 8: Staffing
Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Recruit to all vacancies In addition the Trust Board is asked to consider the implementation of administrative support in this area, through established governance processes to enable timely admission and discharge processes, to provide a consistent patient facing member of staff to welcome patients, and to support clinical staff with administrative duties thus freeing up clinical capacity	£150,000.00
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Recruit to all vacancies in Maternity Assessment Suite 2. Amend the admin requirements for Triage in the next staffing review for consideration as part of annual planning.	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Strengthen escalation processes and ensure these are reflected in the appropriate guideline	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Recruit to all vacancies, birth rate plus approvals to date include the allowance for this.	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Telephone triage to be used by all women, regardless of the intended place of birth. SOP for MLC and SOP-190 to reflect consistent guidance that women should only contact the maternity triage if any concerns, when asking for advice or when in labour. 2. Maternity triage staff to complete training for the use of the single point of access and the single telephone line.	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. MAS manager, lead obstetrician and Practice educator to update the TNA EBG0091 to include Maternity Triage specific training	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. MAS manager, lead obstetrician and Practice educator to update the TNA EBG0091 and develop a specific training programme exclusively for maternity triage (MAS) maternity staff. This should be reviewed on an annual basis	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or		No further action required	

when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	workforce shortages.	Fully in place, embedded and evidenced		
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing of staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Update maternity staffing policy to include telephone triage midwife	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Consider implementation of more than twice daily, in person ward round in MAS by the obstetric consultant on call	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. SOP to specifically note the criteria to ensure the most senior obstetrician on call for labour ward and the maternity unit coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. SOP to also reflect the need for more than twice daily ward rounds 7 days a week. (Lead obstetrician, MAS manager, Matron for Complex care)	
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Telephone triage to be used by all women, regardless of the intended place of birth. SOP for MLC and SOP-190 to reflect consistent guidance that women should only contact the maternity triage if any concerns, when asking for advice or when in labour. 2. Maternity triage staff need to complete training for the use of the single point of access and the single telephone line.	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle £150,000.00
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site captures this data	Please outline what support you require from your trust board below		
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site Partially captures this data	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Launch SafeCare in maternity to better track staff redeployment.		

Principle 9: Equity and equality Services must use data and targeted action to identify and reduce inequalities.			Principles menu Previous1234567810Next										Estimated cost to progress compliance of specification standard
Dashboard													
Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance										Total estimated cost to implement this principle £0.00
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Continue with ongoing work around the Health Inequalities workstream, with clear metrics and timeframes for progress (Consultant MW and CI lead MW). 2. Strengthen maternity training to focus on the importance of acknowledging and understanding inequalities experienced by service users when accessing care via Maternity triage (Practice Educator)										
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomic factors.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Continue with ongoing work around the Health Inequalities workstream, with clear metrics and timeframes for progress. (Consultant Midwife and CI lead MW)										
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Continue with ongoing work around the Health inequalities workstream, with clear metrics and timeframes for progress. (Consultant Midwife and CI lead MW)										
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focussed on maternity safety, experience, equity and outcomes.	Fully in place, embedded and evidenced	No further action required										
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Maternity training to be focused on the importance of acknowledging and understanding inequalities, use a reflective patient experience in MAS when accessing care via Maternity triage Ppractice Educator) 2. Participate in the National Perinatal Equality and Anti-Discrimination Programme										
Metrics	Data captured per site	Support required from Trust Boards to progress the metric										Total estimated cost to implement this principle £0.00	
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.													
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language.	Site Partially captures this data	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight.											

Why: helps identify variation and potential inequality in access, experience and outcomes.

1. Establish dataset from metrics collected in Principle 1 to establish what data can be disaggregated

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Principle 10: Data and measurement Data must drive oversight, learning from incidents and continuous improvement.		Principles menu Previous123456789Next										progress compliance of specification standard
Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance									
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.	1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of a reporting schedule and a Maternity Trisge Specific data set/dashboard									
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.	1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of a reporting schedule and a Maternity Trisge Specific data set/dashboard									
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of a reporting schedule and a Maternity Trisge Specific data set/dashboard									
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.	1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of a reporting schedule and a Maternity Trisge Specific data set/dashboard									
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).	1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Fully in place, embedded and evidenced	No further action required									
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.	1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of a reporting schedule and a Maternity Trisge Specific data set/dashboard									
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.	1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Requirement from Trust Board is to monitor the services progress against the actions below by routine governance reporting systems. This will be in the form of an action plan which will be presented to Safety and Quality Committee for scrutiny and then to Trust Board for oversight. 1. Development of a reporting schedule and a Maternity Trisge Specific data set/dashboard 2. Reinforce the information on the Trust website, develop clear and transparent information in plain language about the data and information used and collected and how this supports maternity care.									
Dashboard		Principles menu Previous123456789Next										total estimated cost to implement this principle £0.00



Board of Directors

Meeting of the	Board of Directors	25.09.2026	
Title of Report	Maternity and Neonatal Services Baseline assessment against the 10-Point Plan		
Report Author	Emma Ashton– Divisional Midwifery & Nursing Director		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board of Directors is asked to: i. Reviews and approves the self assessment for the perinatal 10 point plan and the triage self assessment for submission to NHS England.		
	Decision ☒	Assurance ☐	Information ☐
Executive Summary	This report provides the Maternity and Neonatal services baseline assessment against the national 10-Point Plan developed in response to the Baroness Amos Independent Investigation into Maternity and Neonatal Services in England, this includes the self assessment of triage standards. The self assessment for triage is contained within the adjoining report. There is a national requirement that Trusts submit this tool and associated evidence to NHS England by 25th September 2026. A further submission is then required to NHS England by 31st December 2026 to provide an update on progression with meeting these actions. The 10 point plan assessment demonstrates that the services and Trust have established many of the key governance, safety and quality assurance processes required; however, several areas require further development before full compliance can be achieved. Of the 26 deliverables assessed: • 13 (50%) were rated Compliant • 12 (46%) were rated Partially Compliant • 1 (4%) was rated non-compliant • 1 was Not Applicable (Homebirth risk mitigation action where significant risks were not identified) Overall, the service demonstrates strong performance in governance, board oversight, patient safety, complaints management, duty of candour, homebirth review, and mortality oversight. The principal areas requiring improvement relate to workforce capacity, maternity experience reporting, health inequalities reporting, Martha's Rule implementation, and maternity triage performance monitoring. The services and Trust have largely established the governance arrangements required under the 10-Point Plan: • Directors of Midwifery, Obstetric and Neonatal Clinical Directors routinely attend Trust Board discussions relating to maternity and neonatal services.		

	- Executive portfolios clearly identify the Chief Nursing Officer as the executive lead for maternity and neonatal services; this has recently been extended to shared leadership between the Chief Medical Officer and Chief Nursing Officer. - Board-level oversight of maternity and neonatal safety, workforce, quality and risk is well established. The services and Trust have demonstrated strong compliance in areas associated with patient safety and organisational learning: - Full implementation of the Patient Safety Incident Response Framework (PSIRF). - Established processes for thematic review of incidents, complaints and claims. - Robust arrangements for open learning, compassionate engagement with families, and Duty of Candour. - Board review of mortality, PMRT, Human Tissue Authority findings and wider mortality governance. The Trust is compliant with several key workforce safety standards. An urgent review of homebirth services has been completed, benchmarked against regional work and supported by an action plan. The Board has confirmed that it is assured regarding the safety and quality of the current homebirth service. The Trust submitted the required Board Assurance Statement and has strong mortuary governance arrangements. However, the required review of incident records covering the previous 10 years remains ongoing and will be presented to the Safety and Quality Committee in October 2026. The areas that are partially compliant will be actioned, with evidence strengthened and progress reported by the next submission date of 31 December 2026. In conclusion, the Maternity and Neonatal services demonstrate a strong foundation of governance, safety oversight, incident management, workforce monitoring and board engagement, with approximately half of all deliverables already fully compliant. The most significant risks relate to workforce establishment, implementation of Martha's Rule, health inequalities reporting, maternity experience intelligence, maternity triage monitoring and completion of the internal resource deployment review. The next steps are to develop a comprehensive costed plan for consideration through financial governance processes, ensuring that the Trust makes an informed decision on progressing towards compliance with the 10-Point Plan requirements. Actions that do not require financial decisions have commenced and will be tracked through the agreed maternity and neonatal reporting mechanisms. Financial components will be reported through the business planning processes, and the Safety and Quality Committee and Board will be kept apprised of progress through monthly and bi-monthly reporting mechanisms.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	

Committee Approval:	NA	NA
Operational Group Review:	NA	Date:
Link to Board Assurance Framework:	PR1 – Patient Safety and Experience within the Urgent and Emergency Care Pathway PR2 – People Experiencing Health Inequalities PR7 – Experience of Under-Represented Staff Groups PR8 – Experience of Staff and Levels of Staff Satisfaction	
Appendices	Ancillary Report 1 Maternity and Neonatal services baseline assessment against the national 10-Point Plan	

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



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

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

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

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

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec): Sarah Morrison 22-Sep-26
Trust Board sign off date: 25/09/2026

Trust Board Assurance Template						
No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference <i>Please input reference number as listed in 3. Evidence Log tab</i>	Gaps in Assurance <i>Please provide detail of any gaps in assurance</i>	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant		The Martha's rule (part 2) daily wellness questions have not yet been embedded.	1. Guideline to be amended to ensure that questions are on the template 2. Ongoing work with EPR provider (BadgerNet) to implement digital form 3. Audit to be established to monitor compliance with daily checks 4. Work underway to develop maternity and neonatal specific information	Launch webinar attended by Divisional Midwifery and Nursing Director and Consultant Midwife on 12th August 2026 A 24 hours a day 7 days a week urgent escalation pathway already exists in the Trust and Trust has a Lead Clinician for Martha's Rule
EV-03						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcomes & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-01 EV-02 EV-03 EV-04 EV-05 EV-06	Data is recieved on a monthly basis but is only collated into a report on a quarterly basis	1. To meet with Patient Experience lead for the Trust to look at data sources and how this can be delivered on a monthly basis. 2. Consideration of maternity experience data to be included in maternity dashboard	A quarterly patient experience report which goes to a committee of the Trust Board, and to Perinatal Safety Champions meeting. Patient experience is also included in the biannual perinatal safe staffing report which goes to Trust Board. Intelligence from MNVP goes to Trust Board as part of the Perinatal safety report. Monthly FFT oversight in S&Q committee for maternity and neonates
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-01 EV-04 EV-07 EV-08	The Trust Board does not currently receive and publish this information	1. To meet with Patient Experience lead for the Trust to look at data sources and how this can be delivered on a monthly basis. 2. Consideration of maternity experience data to be included in maternity dashboard	Trust Board papers are published bi-monthly and patient feedback is included in this
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-01 EV-04 EV-08	Data around patient feedback is not currently disaggregated and the Trust board does not therefore analyse this currently	1. To meet with Patient Experience lead for the Trust to look at data sources and how this can be delivered on a monthly basis. 2. Consideration of maternity experience data to be included in maternity dashboard	Annual picker survey currently provides disaggregated data
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant	EV-09	Need for an updated JD and paper this will be approved in the September ARTE committee	1. Director of corporate affairs will updated the Chief medical officers JD to make this explicit	The executive portfoliodescription makes explicit reference to the CNO being the maternity and neonatal executive lead. The CMO JD and executive portfolio descriptor will be updated.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Compliant	EV-10			Divisional Midwifery and Nursing Director, Divisional Nursing Director for Childrens services, Clinical Director for Obstetrics and Clinical Director for Neonates are all invited to attend Trust Board when there is an agenda item.
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	EV-11	Perinatal Team have onboarded with the PEADP programme of work which is due to commence in January of 2026. Chief Nursing Officer is to be Executive sponsor. Agreement for staff to be released to participate		The team the launch event on 4th September 2026 - will have more information about what is involved with this
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-12	This has not previously been included however work has taken place as part of the RHO project.	1. Link with Deputy CNO - plan in place to deliver first draft dashboard by 30th September 2026 2. Deputy CNO to reflect plan for enhanced CoC in health inequalities paper	Gathering disaggregated data for maternity services - Plan in place for enhanced CoC
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Compliant	EV-11			
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-13 EV-14			

6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? <i>(In line with MIS Year 8)</i>	Compliant	Awaiting evidence from Lauren			
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? <i>(In line with MIS Year 8)</i>	Partially compliant	EV-16	Neonatal Medical 4 hours short New ACD report says that we are now not compliant as 2 neonatal nurses short of acuity assessment. Also underfunded for specialist roles and transitional care.	Plan in place to review job plans and then look at potential opportunities for recruitment and consideration of a business case if required.	
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? <i>(In line with MIS Year 8)</i>	Partially compliant	EV-13	Funding is over a 2 year period with final funding being released in March 2027	Recruitment will take place as soon as funding is available	
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? <i>(In line with MIS Year 8)</i>	Compliant	EV-13			
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV-11 EV-13 EV-14			
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Non-compliant	Evidence not available	This piece of work has not specifically been addressed in a board paper.	Details of this will be included in the next Biannual safe staffing paper	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV-11 EV-17 Awaiting action plan			Benchmarking against regional work has been completed and action plan in place. Further benchmarking will be undertaken once national guidance has been published.
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable				
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-019 EV-020 EV-021 EV-022			
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-03 EV-11 EV-13 EV-23			
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-19 EV-20 EV-24			
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	EV-14 EV-25	Triage audit completed and submitted as part of the 25 September return.	Triage self assessment completed in line with direction from NHS England.	
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV-11 EV-14	Not all of these metrics are currently captured	To update the data being collected and to create a Maternity Triage specific dashboard based upon the requirements of the new national framework	Some data is being captured and reported to Trust Board but this needs to be strengthened based upon the new framework

9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	EV-25	Triage self assessment tool completed and associated action plan developed.	The Safety and Quality committee will oversee the progress against the actions agreed for perinatal services. Whole service action tracker will be developed to monitor the implementation of Ockenden/Amos/Thirlwall recommendations.	
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-10 EV-26			
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	EV-26 EV-27 EV-28 EV-29 EV-30 EV-31 EV-32	A review of incident records over the last 10 years is in progress but has not yet been completed and reported to Safety and Quality committee.	Review underway, results to be reviewed and scheduled for the October Safety and quality committee.	There is now a schedule for the oversight at Trust Boards regarding mortuary care.

Submission B: Progress against baseline (December 2026)



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

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

Report signed off by Trust Board (named Exec):

Trust Board sign off date:



									To be completed by Regions	
No.	Deliverable	Baseline Compliance Rating	Current Status	RAG	Evidence ID Please input reference number as listed in 3. Evidence Log tab	Key Gaps / Risks	Improvement action required	Due Date(s)	Regional Compliance Rating	Comments
1. Listening to women and families by rolling out Martha's Rule										
1.1	Is the trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Partially compliant							Non-compliant	
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level										
2.1	Has the trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant								
2.2	Is the trust board continuing to receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant								
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant								
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care										
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant								
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Compliant								
5. Addressing inequalities in maternity and neonatal outcomes										
5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant								
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant								
5.3	Is the trust board receiving reviewing and acting on (through the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	Compliant								
6. Ensuring 24/7 safety and responsiveness of services										
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum 80% consultant presence in defined acute care situations?	Compliant								
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (52 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Compliant								
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	Partially compliant								
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	Partially compliant								
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.27	Compliant								
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?									
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Non-compliant								
7. Trust review of homebirth services										
7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	Compliant								

7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable									
8. Responding to incidents, complaints and concerns with humanity and candour											
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant									
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant									
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant									
9. Deliver safe and effective triage in maternity services											
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant									
9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequality?	Partially compliant									
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant									
10. Post death care											
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2028?	Compliant									
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant									



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

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EV-16	6.3	ACD report	NWNODN ACD 2526 report	01/09/2026	Neonatal Services		Regional Network assessment of neonatal staffing	Strong
EV-17	7.1	SOP	Homebirth SOP	31/07/2026	Maternity Services		Current Homebirth Operational Policy	Adequate
EV-18			Homebirth action plan					
EV-19	8.1							
	8.3	Trust Policy	Being open policy	14/01/2025	Trust Board		Current Trust Policy	Strong
EV-20	8.1		Perinatal Mortality Review Tool (PMRT) and Child Death Overview Panel (CDOP)					
	8.3	Trust SOP		21/04/2026	Maternity Services		Current Trust SOP	Strong
EV-21	8.1	Trust Policy	Patient Safety Incident Response Framework (PSIRF) Policy	23/07/2026	Trust Board		Current Trust Policy	Strong
EV-22	8.1	Trust Plan	Patient Safety Incident Response (PSIRF) Plan	23/07/2026	Trust Board		Current Trust Plan	Strong
EV-23	8.2	Report	Maternity Clinical Claims, Complaints and incidents triangulation report - Division of Women and Children's. Quarter 1 April - June 2026	23/07/2026	Maternity services			Strong
EV-24	8.3	Letter template	PMRT letter template for parents		Maternity Services		Provided to parents when a PMRT review is required	Strong
EV-25	9.1	Benchmarking tool	Maternity Triage Specification Benchmarking Audit 1	17/09/2026	Maternity Services		Completed Benchmarking tool	Strong
EV-26	10.1	Board Report	Board Assurance Statement	06/08/2026	Chief Medical Officer		Presented to Trust Board	Strong
EV-27	10.2	Board Report	Annual Mortality, LEDER and PMRT Report	06/08/2026	Chief Medical Officer		Presented to Trust Board	Strong
EV-28	10.2	Board report	Annual Mortality Report 2025-2026	26/06/2026	Chief Medical Officer		Presented to Trust Board	Strong
EV-29	10.2	Board report	Annual Mortality Report 2025-2026 - Appendix	26/06/2026	Chief Medical Officer		Presented to Trust Board	Strong
EV-30	10.2	Board report	Biannual Mortality Report 2025-2026	30/01/2026	Chief Medical Officer		Presented to Trust Board	Strong
EV-31	10.2	Board report	Human Tissue Authority Post Mortem Inspection	30/01/2026	Chief Medical Officer		Presented to Trust Board	Strong
EV-32	10.2	Minutes of Trust Board meeting	Minutes of Trust Board meeting for 6th August showing attendance	30/01/2026	Trust Board			Strong

10-Point Plan for Maternity & Neonatal Services

How to Use This Template



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

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

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

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

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

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

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

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

Rating definitions:

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

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

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation: Lancashire Teaching Hospitals Trust
Report prepared by: Emma Ashton
Report date: 25-Sep-26
Reporting period covered: Jan 26 - 31 August 2026

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

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	1	2
6. Ensuring 24/7 safety and responsiveness of services	7	0	1	2	4
7. Trust review of homebirth services	2	1	0	0	1
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	0	3
9. Deliver safe and effective triage in maternity services	3	0	0	3	0
10. Post death care	2	0	0	1	1

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

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

Evidence: examples



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

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

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.
	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Analytical reports
Action 2	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	- Board report and minutes - Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	- Board ToR - Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	- Job plans - Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	- Board report - Quarterly MIS thematic report - Equity dashboard reports - Core20PLUS reporting - Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	- Maternal Care Bundle implementation plans. - Board report - MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	- Workforce plan - Biannual workforce papers - Staff experience survey - Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (52 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	- Workforce plan - Biannual workforce papers - BAPM workforce standards compliance - Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	- BR+ review and workforce plan - Biannual workforce papers - Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	- Workforce plan - Biannual workforce papers - Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	- Board report and minutes - Biannual workforce papers - Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	- Board report and minutes - Biannual workforce papers - Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	- Board report and minutes - A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services - PSIRF implementation within Maternity and Neonatal Services, governance and review processes. - Process for sharing outcomes and learning from PSIRF reviews with women and families. - Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	- Board report and minutes - Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. - Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	- Board report and minutes - Debrief guidance - Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	Assurance statement
	10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	- Board Report - Review report



Board of Directors

Meeting of the	Board of Directors	01.10.2026	
Title of Report	Maternity Outcomes Signalling System Drill 2026		
Report Author	Emma Ashton– Divisional Midwifery & Nursing Director		
Lead Executive Director	Sarah Morrison – Chief Nursing Officer/Deputy Chief Executive Officer		
Recommendation/ Actions required	The Board is asked to receive the outcome of the MOSS drill , noting its review and scrutiny by Safety and Quality committee.		
	Decision ☐	Assurance ☐	Information ☒
Executive Summary	It is a requirement of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 8 that Trust Boards and maternity services are expected to: • Have a process to review MOSS reports routinely and ensure oversight through maternity governance structures. • Undertake a Critical Safety Check whenever a MOSS signal is triggered. • Ensure findings and actions from MOSS reviews are escalated through the Perinatal Quality Oversight Model (PQOM) and local governance arrangements. • Provide Board assurance that MOSS signals have been reviewed, themes identified, actions implemented, and learning monitored. • Demonstrate that emerging risks identified through MOSS are triangulated with: - o PMRT reviews - o HSIB/MNSI investigations - o SI/PSIRF learning - o Patient experience and complaints - o Workforce and safety metrics. If a Trust does not receive a MOSS signal then it is expected that Maternity services will run a drill scenario using the national template and SOP, to test the processes involved and that this should be shared with the Trust Board for oversight. The Maternity Oversight Safety Signalling (MOSS) Critical Safety Check (Drill) was undertaken in August 2026. This was to assess the safety of intrapartum services following a simulated Maternity Outcomes Signal System (MOSS) alert and to determine whether any immediate safety concerns required escalation. The review examined recent term deaths, safety culture, leadership, workforce, operational performance, multidisciplinary working, and compliance with key maternity safety standards. Three recent term deaths (two stillbirths and one neonatal death) were reviewed. The multidisciplinary investigations and reviews concluded that care was delivered in line with national and local standards. Whilst some learning opportunities were identified, none were considered contributory to, or likely to have changed, the outcomes. There was no evidence that recent deaths were caused by deficiencies in maternity care.		

Robust governance arrangements were found to be in place, including PMRT reviews, After Action Reviews, thematic learning reviews, and executive oversight. Strong compliance was demonstrated with:

- Saving Babies' Lives Care Bundle requirements.
- Mandatory maternity and neonatal training standards.
- Daily multidisciplinary safety huddles and structured SBAR handovers.

Staff reported a strong commitment to delivering safe, compassionate care and good multidisciplinary support. Progress is being made through the Obstetrics & Gynaecology Cultural Improvement Action Plan. Service users largely reported positive experiences, particularly regarding compassionate care, continuity, and personalised support. Opportunities for improvement were identified around communication, perinatal mental health support, inclusivity, and engagement with seldom-heard communities.

Obstetric consultant workforce gaps were identified, particularly within maternal and fetal medicine services. Midwifery vacancies and maternity leave resulted in a staffing gap of 15.73 WTE, although safe staffing levels were maintained through mitigation measures.

Staff highlighted concerns regarding:

- Medical staffing capacity and skill mix.
- Availability of specialist mental health support.
- Equipment availability and estate limitations.
- Pressures within postnatal and transitional care services.

Focus on stabilising the medical workforce continues to be a key priority.

There is an improved position since the MOSS drill by one WTE Consultant with a new colleague started in September. A second recruitment has been successful and will start in February 2027. Following further consideration of the risk, the decision to recruit to a further two additional Obstetricians has commenced in anticipation of continued maternal and fetal medicine oversight requirements and Caesarean Section demand. These actions alongside fixed term appointments whilst substantive colleagues join aim to mitigate the risks identified. Plans are progressing to create separate Obstetric and Gynaecology Consultant rota's, this is in addition to the steps taken in year to establish the two tier resident doctor, out of hours provision.

The Midwifery workforce also continues to be a priority with 13.4WTE appointed in August, this includes use of the agreed risk based over offer to mitigate the risk of lower than plan new recruits, these will start in October 2026. A further 5WTE are in the recruitment process in anticipation of the known maternity leave and turnover.

A number of operational standards were found to not be consistently achieved. These included a decline in performance of maternity triage's ability to see women within 15 minutes of attendance. This is relation to the volume and time of attendance of women.

Concerns around commencement of induction of labour, there is a improvement group in place with service redesign in progress to improve this experience for women, the recruitment activity will mitigate this and the ability to complete category 1 and 2 caesarean sections within the expected timeframes.

The safety drill found no evidence of systemic failures contributing to recent term deaths, and the service demonstrates several strengths including effective governance, strong training compliance, multidisciplinary safety processes, and ongoing improvement programmes. However, operational and workforce pressures persist, particularly relating to obstetric staffing, induction of labour performance, and caesarean section decision-to-delivery intervals. A new safety risk has been identified regarding caesarean section timeliness, and a formal improvement plan is required.

	The review has identified opportunities to strengthen data quality in relation to a number of areas that are not routinely monitored and a working group has been established. The final MOSS Rating was assessed as being AMBER/RED. This is because there is at least one known safety issue within the intrapartum service for which a fully agreed action plan is not yet in place. Following the conclusion of the drill the Maternity service has developed an action plan (Ancillary report 2) and progress against this will be monitored and this is shared as part of this update and will be monitored through the Board reporting governance arrangements in place.	
Link to Strategic Objectives 2025/26	Patients – deliver excellent care: Improve outcomes, reduce harm and deliver a positive patient experience.	☒
	Performance – deliver timely, effective care: Deliver agreed trajectories in clinical performance.	☒
	People – be a great place to work: Create an inclusive culture with leaders at every level leading colleague engagement.	☒
	Productivity – deliver value for money: Deliver the agreed financial plan including waste reduction programme, maximising use of resources.	☒
	Partnership – be fit for the future: Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions.	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Review:	Safety and Quality Committee	Date: 25 September 2026
Link to Board Assurance Framework:	PR1 – Patient Safety and Experience within the Urgent and Emergency Care Pathway PR2 – People Experiencing Health Inequalities PR7 – Experience of Under-Represented Staff Groups PR8 – Experience of Staff and Levels of Staff Satisfaction	
Appendices	Ancillary Report 1 – MOSS Critical Safety Check (Drill) – August 2026 Ancillary Report 2 – MOSS drill action plan	

Annex 9: Critical Safety Check (drill version) Undertaken 17 August 2026

IMPORTANT NOTE: This version of the critical safety check has been adapted to help services carry out a test drill. It is not intended to be used in response to a real signal. Services should use the critical safety check in Annex 1 in response to a real signal.

The **critical safety check** (drill version) is a rapid, structured assessment of key intrapartum care operational safety processes led by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the trust board (see responsibilities below). It is not designed to replace comprehensive audits, investigations or case reviews. Perinatal leadership teams should practice at least one annual drill using the critical safety check, so they are prepared to respond when real signals occur. An annual drill does not need to be carried out if a service has already responded to a real signal within the calendar year using the critical safety check (Annex 1).

Objective: To practice the response to a signal and conclude whether an intrapartum service has a safety issue that needs to be addressed.

Areas of focus: Improvement timelines from known safety themes, leadership and culture, time-limited safety care pathways, risk assessment and escalation processes and safe staffing.

Responsibilities: Completed by the perinatal leadership team and approved by an accountable trust board executive (i.e. chief nurse, chief medical officer or executive trust board safety champion) within 8 working days from a signal. In real level 2 signals, an external peer review of the check should also happen before executive sign-off (see p.6 of the [standard operating procedures](#)). We recommend trying to test this as part of the drill. If a signal is received over the weekend or on a bank holiday, the timeline starts from the next working day. The check should be approved face to face or virtually where possible.

After completion and approval: Share the completed critical safety check with ICBs and regions for oversight and support if a safety issue is identified. ICBs or regions can stand down if a check does not conclude there is a safety issue.

Assumed knowledge/processes in place: The perinatal leadership team should have the below information available prior to the critical safety check (drill version):

Knowledge/process	Include summary or refer to relevant documents for the attention of accountable trust board executives
Have an early understanding of the causes of death for term events over the past 3 months	Yes, please see executive case summaries below: Case 1: This case involved a stillbirth of baby at 41+2 weeks' gestation. Throughout the pregnancy, fetal growth, CTG monitoring, Doppler studies and ultrasound assessments were reported as normal, including investigations performed less than 48 hours before confirmation of the baby's death. The review found no evidence of fetal compromise prior to the diagnosis of intrauterine fetal death. The local review identified several opportunities for improvement in care processes, including earlier consultant obstetric involvement for a late-booking pregnancy, follow-up of thyroid function tests, escalation of repeated inconclusive urine results, completion of additional investigations for proteinuria, and improved adherence to pathways for women declining induction of labour. However, clinical review concluded that none of these issues would have altered the outcome. Case 2: This case involves a neonatal death of a term male infant born by Category 2 caesarean section at 39+1 weeks' gestation. The decision to delivery interval was 92 minutes, with delay attributed to acuity. The baby was delivered in poor condition with severe metabolic acidosis, significant growth restriction, multi-organ dysfunction and neonatal encephalopathy, requiring intensive neonatal care. Despite maximal treatment and therapeutic cooling, the baby's condition deteriorated and he died. Post-mortem findings demonstrated extensive hypoxic-ischaemic injury and evidence of significant underlying pathology. The review concluded that antenatal surveillance, fetal growth monitoring, CTG interpretation, escalation pathways, neonatal stabilisation and intensive care were delivered in accordance with national and local guidance. No concerns were identified regarding clinical decision-making, communication of critical information, or organisational failures that were considered contributory to the baby's death. Whilst the birth did not meet the 75-minute standard for Category 2 caesarean section, due to additional risk factors it was felt that birth within this standard would not have altered the outcome.

	Case 3: A multidisciplinary review was undertaken following the intrauterine death of a baby at 38+5 weeks' gestation secondary to a concealed placental abruption. The mother had received consultant-led antenatal care due to several recognised risk factors, including raised BMI, previous traumatic birth, previous postpartum haemorrhage, anxiety, smoking in early pregnancy, and a family history of pre-eclampsia. Antenatal surveillance, including fetal medicine review for mild ventriculomegaly, was undertaken appropriately and findings remained stable throughout the pregnancy. Two days prior to the baby's death, the mother attended with reduced fetal movements. Assessment, including CTG monitoring, was reassuring and management was in line with national guidance. She subsequently re-presented with severe abdominal pain and spontaneous rupture of membranes, where ultrasound confirmed intrauterine fetal death and findings consistent with a concealed placental abruption. The mother's condition rapidly deteriorated due to disseminated intravascular coagulation (DIC) and major obstetric haemorrhage. A multidisciplinary team response was initiated, including activation of the Major Obstetric Haemorrhage protocol, blood product replacement, critical care involvement and emergency Category 1 caesarean section. Although the decision-to-delivery interval exceeded the standard 30-minute target, the review concluded that this was clinically justified to allow maternal stabilisation prior to surgery and was appropriate in the circumstances. The review found that antenatal care, management of missed appointments, fetal medicine surveillance, emergency response, obstetric management and critical care support were delivered in accordance with expected standards. No omissions in care, delays, or clinical management issues were identified that were considered contributory to the outcome
Commissioned formal investigations where appropriate	All cases have undergone an After-Action Review (AAR) to identify learning opportunities and provide assurance regarding the care delivered. Case 2 met the criteria for referral to the Maternity and Newborn Safety Investigations (MNSI) programme, and an appropriate referral was submitted. However, the referral was subsequently closed as the parents did not consent to participation in the investigation. Two of the cases have completed a formal Perinatal Mortality Review Tool (PMRT) review, with external representation included within the review panel to provide independent oversight and assurance.

	The remaining case is awaiting final pathology results. Once these results are available, a formal PMRT review will be convened and completed in accordance with national guidance.
Involved families in the investigation process where appropriate and listened to their insights and feedback	All parents were asked for perspectives as part of the investigation.
Emerging and known safety themes with any timelines of action plans to address	During Q1 2026, thematic learning was reviewed from a range of maternity safety processes, including 5 PMRT cases (2 stillbirths and 3 neonatal deaths), 4 MNSI referrals, 3 moderate/severe harm incidents, and 112 rapid incident/thematic reviews relating to OASI, PPH and term admissions to the neonatal unit. Key learning was triangulated: Key Learning Themes Recurring themes identified across reviews were: • Clinical escalation and communication, including the need for clearer escalation pathways and improved use of closed-loop communication and SBAR handovers. • Consistency of clinical guidance, with opportunities to align guidelines covering similar clinical topics to support standardised assessment and management. • CTG equipment availability, particularly within theatre environments, where access to appropriate monitoring equipment was not always optimal. • Sepsis recognition and management, including inconsistent completion of elements of the sepsis care bundle. • Fetal monitoring in labour, with learning relating to compliance with national guidance for fetal monitoring during the second stage of labour in midwifery-led settings. • Interpreter services and health inequalities, highlighting the importance of effective communication and equitable access to care. • Risk assessment, clinical assessment and documentation, particularly in relation to escalation, specialist referrals and pathway compliance. • Recognition of labour progress and neonatal care, including recognition of second stage labour and management of neonatal hypoglycaemia. • Postpartum haemorrhage, including themes relating to uterine atony and induction of labour. • Workforce and service capacity pressures, including availability of transitional care resources and specialist support. Actions Undertaken

	In response to the identified themes, a number of improvement initiatives have been implemented or continue through established workstreams: • Ongoing monitoring of postpartum haemorrhage through the Maternal Care Bundle and PPH Task and Finish Group. • Continued oversight of induction of labour through the dedicated continuous improvement workstream. • Introduction of an RCOG clinical escalation toolkit within maternity training programmes. • Strengthening of the divisional guideline oversight process to improve consistency across policies and pathways. • Progression of the Interpretation and Translation Workstream to improve communication and reduce health inequalities. • Development of the Transitional Care Working Group to address capacity and pathway challenges. • Ongoing improvement work through the MEOWS Working Group and Health Innovation programmes. • Delivery of the Intrapartum Care Action Plan through the Birth Forum. • Review and enhancement of maternity assessment and triage processes, including improvements to escalation pathways, documentation standards and communication processes.
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Advice for completing the check:

- do not share patient identifiable information on this form with anyone who does not have a lawful basis to see it – redact first
- the completed and approved check needs to be shared with ICBs and regions within 8 working days even if not all questions can be completed
- italicised text should be deleted before completing

Section 1 – MOSS pre-completion check

This section provides accountable trust board executives with additional context that may explain the signal and whether the pre-requisites for implementing MOSS are in place.

MOSS pre-completion check		
Questions	Answer	
	Yes/No	Description

Have you identified an issue with the data displayed by MOSS (for example, an event was not at term or care/delivery did not take place at the site displayed)?	No	<i>If you have raised a data issue here, please can you email the details to the MOSS project team at england.moss@nhs.net so it can be investigated.</i> <i>Perinatal leadership teams should remain curious and proceed with the critical safety check as part of good practice.</i>
Is the trust site a NICU plus cardiac surgery centre?	No	<i>Whilst it is acknowledged that sites that are NICU plus cardiac surgery centres may generate more frequent signals, due to caring for babies with congenital anomalies that have a known high risk of stillbirth or neonatal death, perinatal leadership teams should remain curious and still proceed with the critical safety check as part of good practice.</i>
Were any of the events in MOSS that occurred over the last 3 months unavoidable? Please state why.	No	<i>Perinatal leadership teams should remain curious and proceed with the critical safety check as part of good practice.</i>
Are the pre-requisites for implementing MOSS in place (page 5-6 of standard operating procedures)?	Partially	<i>Maternity services must establish the pre-requisites to implement MOSS effectively. If maternity services are still working towards this, perinatal leadership teams should still proceed with the critical safety check in the best way possible.</i>

Section 2 – are key safety elements of your intrapartum service in place?

Please complete this section focussing on the activity of your intrapartum service **over the last 3 months**.

Safety culture - conversations with staff and service users		
Questions	Answer	
	Yes/No	Brief description with any action taken (bulleted only)
1. Are the perinatal leadership team, accountable trust board executives and staff (on	Yes, this is working well	N/A

labour ward, triage and birth centre) working well together?		
2. How do you measure your leadership culture and how frequently is this done? What actions have you taken?		The Obstetrics & Gynaecology Cultural Improvement Action Plan is making good progress in establishing the foundations for long-term cultural change. Thirteen staff feedback sessions have been completed across professional groups, leadership culture development sessions are underway, and the Unit Coordinator role has been successfully implemented. Key priorities now focus on strengthening role clarity, embedding behavioural standards, improving multidisciplinary working, and enhancing staff experience. While progress has been strongest within midwifery and nursing leadership teams, several actions involving the medical workforce, team development, inclusion, freedom to speak up, and colleague engagement remain in the early stages or have yet to commence, largely due to leadership vacancies and workforce pressures. Overall, the programme is progressing as planned, with clear leadership commitment and a broad portfolio of actions in place, although sustained focus will be required over the next 6-12 months to deliver the intended cultural transformation across all professional groups.
3. What have MNVP leads or other service users fed back that they feel could be improved?		There is currently no MNVP Lead available during completion of this report. However, review of the most recent MNVP report presented through the Trust's Safety & Quality governance structure provides valuable insight into service user experience and areas for ongoing improvement. Overall, feedback was positive regarding the quality of maternity care, with women describing compassionate and supportive staff, positive experiences of continuity of care, informed decision-making, and respect for individual preferences. The value of having a named midwife was a recurring theme, particularly for women requiring additional emotional or mental health support. The report identified several opportunities to further improve the patient experience. These include strengthening communication and providing timely updates during labour, improving access to specialist support services for women affected by pregnancy-related trauma and loss, enhancing perinatal mental health support, and continuing to develop continuity of care models. The report also highlighted the need to ensure services are inclusive and responsive to the needs of LGBTQIA+ families and non-birthing partners. Further priorities include increasing engagement with seldom-heard communities, including ethnic minority groups, asylum-seeking families and LGBTQIA+ communities, alongside strengthening volunteer capacity to support

		broader and more representative service-user engagement. Overall, whilst clinical care was viewed positively, the feedback suggests that continued focus on communication, accessibility, inclusivity and emotional support would further enhance the experience of women and families using maternity services.
4. From your walkarounds and conversations with staff:		
a) What do staff feel is working well in providing safe care in labour and birth?		Staff consistently reported a strong commitment to providing safe, compassionate care and described going above and beyond to meet the needs of women and babies, often despite significant workload pressures. Staff highlighted the dedication of the multidisciplinary team and their willingness to support one another to ensure patient safety is maintained.
b) What do staff feel could be improved to achieve better outcomes?		Staff Walkaround Findings - 11 August 2026 A staff walkaround was undertaken on 11 August 2026 to gather feedback on what is working well in providing safe care during labour and birth, and what improvements could support better outcomes. Staff advised that medical staffing capacity is not always adequate and concerns were raised regarding the overall skill mix within the workforce. Midwives reported that they do not always feel heard when escalating concerns to medical colleagues, and staff highlighted limited support from specialist services, particularly psychiatry, when caring for women with mental health or mental capacity concerns. Concerns were also raised regarding the estate and availability of equipment, with staff reporting that the environment is not always fit for purpose and that there is insufficient access to devices such as iPads to support contemporaneous record keeping while in-between patients. Operational pressures were a recurring theme. Staff reported that the number of inductions of labour undertaken each day can exceed service capacity and that increasing numbers of caesarean sections place additional demands on postnatal staffing, particularly in relation to post-operative observations. Workload across the postnatal ward was described as high, with staff feeling that workforce requirements do not always reflect the needs of both mother and baby. Concerns were also raised regarding Transitional Care capacity, which is currently limited to four patients, resulting in occasions where maternity staff have provided additional support. Staff further reported that workload pressures can limit opportunities to provide breastfeeding support, as higher-risk mothers and babies often require prioritisation.

Are you achieving safety timelines for these care pathways?

5. Is the maternity service achieving a triage of new cases within 15 minutes of presentation?	Yes - plans are already in place to maintain/improve this	Overall, yes, although performance has deteriorated in May and June 2026. Data from the Maternity Assessment Suite shows that the majority of women were seen by a midwife within 15 minutes of presentation across all reported months. <table><tr><th>Month</th><th>% Percentage</th></tr><tr><td>April 2026</td><td>95.1%</td></tr><tr><td>May 2026</td><td>87.4%</td></tr><tr><td>June 2026</td><td>89.5%</td></tr></table> Key findings: • Performance was consistently above 92% between January and April 2026, peaking at 95.1% in April. • A notable decline occurred in May (87.4%) and June (89.5%), coinciding with a rise in the number of delayed assessments. Delays increased from 50 cases in April to 125 in May and 113 in June. • The presentation identifies the peak period for delay as 12:00-14:00, with most midwife delays occurring between 10:00 and 16:00, attributed to midwife and maternity support worker staffing gaps. • Actions have been taken, including adjusting twilight shifts to 11am-11pm and obtaining approval for an additional 5.51 WTE staffing uplift, although recruitment is still pending.	Month	% Percentage	April 2026	95.1%	May 2026	87.4%	June 2026	89.5%
Month	% Percentage									
April 2026	95.1%									
May 2026	87.4%									
June 2026	89.5%									
6. Is the maternity service achieving commencement of induction of labour (IOL) within 6 hours from point of admission for induction (from home or ward)	No - we are putting plans in place to improve this but are not on track	Between 1st May 2026 – 31st July 2026 57% of women achieved induction of labour within 6 hours from the point of admission. A continuous improvement project has been established to work towards improving induction of labour experiences; however, progress and action need reviewing. Some of the changes needed are linked to reconfiguration of staffing to improve flow and this work is in progress but has been delayed because of acuity and vacancy pressures.								
7. Is the maternity service achieving category 1 caesarean sections as soon as possible and usually within 30 minutes	No - we have not yet agreed a plan	Between 1st May 2026 – 31st July 2026 68% of Category 1 caesarean sections were within 30 minutes of decision to deliver.								

of the decision to deliver?	to put any improvements in place	Further analysis of cases not meeting the decision to deliver target is required to understand the factors affecting non-compliance. Compliance figures will be reported on a monthly basis via Maternity Safety & Quality meetings and form part of our maternity dashboard. In August 2026, commencement of the Tier 2 workforce expansion has allowed junior and senior registrar level resident cover. It is anticipated that this will improve compliance with decision to delivery time intervals.
8. Is the maternity service achieving category 2 caesarean sections as soon as possible and usually within 75 minutes of the decision to deliver?	No - we have not yet agreed a plan to put any improvements in place	Between 1st May 2026- 31st July 2026 63% of Category 2 caesarean sections were within 75 minutes of decision to deliver. Further analysis of cases not meeting the decision to deliver target is required to understand the factors affecting non-compliance. Compliance figures will be reported on a monthly basis via Maternity Safety & Quality meetings and form part of our maternity dashboard. In August 2026, commencement of the Tier 2 workforce expansion has allowed junior and senior registrar level resident cover. It is anticipated that this will improve compliance with decision to delivery time intervals.
Are you achieving regular multi-disciplinary team (MDT) communication of known or emerging risk factors on the labour ward?		
9. Are you achieving at least one MDT huddle every day on the labour ward based on NHSI guidance ?	Yes - this is already in place	A maternity safety huddle takes place every morning at 09:30am.
10. Do your huddles always include a consultant obstetrician, anaesthetist, midwifery co-ordinator and member of the neonatal team?	No/not always - we have not yet agreed a plan to put this in place	The huddles take place with the midwifery unit coordinator, midwives in charge from each clinical area and a member of the neonatal team (typically nursing coordinator). The consultant obstetrician should also attend this huddle, but this depends on clinical activity and urgency. Attendance of an anaesthetist is not currently mandated however this will be discussed in collaboration with anaesthetics. Attendance is monitored.

11. Is the maternity service achieving a structured handover process in the labour ward, such as SBAR or an equivalent, that can manage known or emerging risks and involves the MDT?	Yes - this is already in place	Yes, a structured handover takes place on delivery suite every morning and evening. Every patient is handed over using an SBAR format when moving between locations of care, to identify risks and ensure appropriate management of care.
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Are your teams carrying out appropriate risk assessment and escalation?

12. Is the service achieving compliance with element 4 of the current version of the Saving Babies' Lives Care Bundle ?	Yes - this is already in place	The service confirms that it remains fully compliant with the requirements of the Saving Babies Lives Care Bundle Version 3.2 (SBLCB v3.2). Compliance is monitored through an established performance dashboard, which enabled oversight of key actions, supports the tracking of recommendations, and provides assurance that clinical practice continues to align with national standard and evidence-based guidance.
13. Is the service achieving 90% of attendance in each relevant staff group (as per Maternity Incentive Scheme guidance) at: - fetal monitoring training - multi-professional maternity emergencies training - neonatal resuscitation training	Yes - this is already in place	The June 2026 Maternity Incentive Scheme (MIS) Year 8 midpoint review (April – June 2026) demonstrates that the service is achieving the required 90% compliance threshold across all relevant staff groups for mandatory maternity and neonatal training. Compliance levels exceed the national standard in all three required training areas, providing assurance that staff are maintaining the competencies required to deliver safe maternity and neonatal care. - Fetal Monitoring Training achieved 100% compliance across all eligible staff groups, including midwives, consultant obstetricians and trainee doctors (235/235 staff trained). - Multi-Professional Maternity Emergencies Training achieved 99% compliance overall (321/324 staff trained), with all eligible staff groups meeting or exceeding the 90% standard. - Neonatal Resuscitation Training achieved 98% compliance overall (313/318 staff trained), with all relevant neonatal and maternity staff groups exceeding the required compliance level. The service has confirmed that the June 2026 position represents the first MIS checkpoint for the reporting year. Ongoing monitoring is being undertaken by the Clinical Education Team to maintain compliance and ensure continued achievement of the Maternity Incentive Scheme requirements. Conclusion: The maternity and neonatal service is fully compliant with Safety Standard B requirements and is successfully achieving the required 90% attendance threshold in all relevant staff groups for fetal monitoring, multi-professional maternity emergencies, and neonatal resuscitation training.

Is there a stable workforce offering safe and effective care during labour and birth?

14. Have staff been redeployed or non-clinical midwifery staff (e.g. managers / specialist midwives) utilised to meet minimum midwifery safe staffing levels as per your trust's safe staffing policy?	Yes	The maternity service experienced ongoing workforce pressures during April to June 2026, with a registered midwifery vacancy rate of 6.51 WTE and a further 9.22 WTE staff on maternity leave, creating a total staffing gap of 15.73 WTE against establishment. Active recruitment measures, including over-offering to newly qualified midwives, have been implemented to address these vacancies and improve workforce resilience. Despite these challenges, the service maintained safe staffing levels across maternity inpatient areas. Registered midwife fill rates remained consistently high throughout the quarter, ranging from 94% to 101%, indicating that staffing levels were sustained in line with the Trust's safe staffing requirements. To maintain safe staffing and service continuity, workforce mitigation measures were utilised, including flexible deployment of staff and proactive workforce management processes. These arrangements enabled the service to continue delivering safe care whilst managing vacancies, maternity leave, and fluctuating demand. The service has utilised staffing mitigation measures, including redeployment and flexible deployment of available staff resources where required, to maintain minimum safe staffing levels. Despite significant workforce pressures, safe staffing standards have been maintained throughout the reporting period through active operational oversight, recruitment initiatives, and workforce planning.
15. Have there been obstetric staffing shortfalls impacting on safe care delivery?	Yes	During the last three months, the Obstetrics and Gynaecology service has experienced medical workforce pressures, primarily affecting consultant staffing across maternal medicine, fetal medicine and gynaecology services. These pressures have arisen due to a combination of long-term sickness, maternity leave, career breaks, restricted duties, and recruitment challenges. By June 2026, consultant availability had reduced substantially, with 27.3% of the funded consultant workforce across obstetrics and gynaecology unavailable for daytime duties and 36.4% unavailable for out-of-hours duties. Within the obstetric service, staffing challenges were particularly evident within the maternal and fetal medicine workforce, where the service faced the loss of a consultant on career break, a consultant on long-term sickness absence, and a further consultant commencing maternity leave from 1 June 2026. This resulted in a significant pressure on specialist maternal medicine provision and created a 3.0WTE gap in the maternal medicine service that could not be fully absorbed by the existing workforce due to the specialist skills required. Despite these workforce challenges, the service maintained safe delivery of acute obstetric services. Emergency pathways, antenatal services and on-call rotas were sustained through enhanced operational oversight, proactive

		rota management and the use of agency and locum support. However, to protect urgent and emergency care, some elective non-cancer gynaecology activity was temporarily reduced or cancelled. A comprehensive mitigation plan was implemented with executive oversight, including: • Weekly staffing meetings and daily operational reviews of rota gaps. • Temporary use of WLI to enable substantive consultants to cover specialist clinic gaps, enabling continuation of specialist services locally • Recruitment to substantive consultant, specialty doctor and senior clinical fellow posts. • Appointment of a consultant with a maternal medicine interest due to commence in September 2026. • Ongoing recruitment to maternal medicine consultant posts with mutual aid support in the interim. • Use of agency medical staff and support requested through the LMNS. • Exploration of insourcing arrangements to maintain specialist service capacity. • Mutual aid requests at ICB and Northwest regional level. • Review of Obstetrics and Gynaecology on-call rotas. • Capacity and demand review of c-sections. • Executive approval to recruit 2 Obstetricians above establishment. • Tier 2 implementation effective from August 2026 The obstetric service has faced sustained consultant workforce pressures throughout the reporting period, particularly within specialist maternal and fetal medicine services. Nevertheless, through active risk management, executive oversight and targeted recruitment initiatives, the service has maintained emergency obstetric provision, antenatal capacity and on-call cover. Recruitment activity with planned new starters and the return of consultants from sick leave are expected to improve workforce resilience during the forthcoming months.
16. Have there been any anaesthetic staffing shortfalls as per RCOA guidance impacting on safe care delivery?	No	There have been no anaesthetic staffing shortfalls identified that have impacted the safe delivery of maternity care during the reporting period (April-June 2026). The service reports that obstetric anaesthetic job plans continue to be prioritised to ensure compliance with Anaesthesia Clinical Services Accreditation (ACSA) standards. Workforce capacity and rota fill rates are reviewed regularly, with escalation processes in place where required to manage any staffing pressures. The report confirms that staffing arrangements remain aligned with Maternity Incentive Scheme (MIS) requirements and that specialist obstetric anaesthetic cover has been maintained throughout the period. Specifically, there have been no occasions where a specialist obstetric anaesthetist has been unavailable for the required 24/7 cover.

		There have been no reported anaesthetic workforce shortfalls during the last three months that have affected service delivery or patient safety. The service has maintained continuous specialist obstetric anaesthetic provision in line with relevant professional standards and national requirements.
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Section 3 – is there any additional information that accountable trust board executives should pay attention to?

Please use this section if there is anything not captured above that you feel executives should pay attention to, explaining potential safety issues in your intrapartum service over the last 3 months.

The MOSS Critical Safety Check found no evidence that recent term deaths were caused by failings in maternity care, with reviews concluding that care was delivered in line with expected standards and that the outcomes were unlikely to have been prevented.

The service has a number of strengths, including effective governance, daily multidisciplinary safety huddles, strong compliance with the Saving Babies' Lives Care Bundle, and excellent mandatory training compliance across maternity and neonatal staff groups.

However, the report identifies ongoing challenges relating to workforce, service capacity and compliance with expected timeframes for induction of labour and category 1 and 2 caesarean sections. Staff raised concerns about medical staffing levels, skill mix, equipment availability, estate limitations, and increasing workload pressures across labour ward, postnatal and transitional care services. Service users highlighted opportunities to improve communication, mental health support, inclusivity and engagement with seldom-heard communities.

Performance concerns were noted in some operational areas. Triage performance has declined in recent months, there continues to be significant pressure on the induction of labour service with only 57% of women having induction started within 6 hours of admission for induction, and Caesarean section response times are below recommended standards, with only 68% of Category 1 and 63% of Category 2 Caesarean sections meeting target times. This data has not previously been reported as part of the maternity dashboard and requires further analysis. Improvement plans for category 1 and 2 caesarean sections were not yet fully agreed at the time of the review.

Overall, the report MOSS Safety Drill report demonstrates areas for improvement that have already been identified through robust governance processes; improvement plans are in place. These areas for improvement have also been identified via external review from the MatNeoIST diagnostic visit undertaken in July 2026. Whilst there are recognised workforce and capacity pressures, these risks are understood and are being actively managed through existing improvement programmes and executive oversight. The MOSS safety Drill report has identified a new safety risk in caesarean section decision to delivery interval target breaches. Whilst no national standard exists for this, an action plan is to be developed to identify factors preventing the organisation reaching a 90% compliance target. This is to be reported on a monthly basis via SPC charts through maternity Safety & Quality meetings to ensure that it receives scrutiny at board level.

Section 4 – conclusion from this critical safety check (drill version)

This section is used to summarise the outcome of the critical safety check (drill version) for accountable trust board executives. If more than one safety issue has been identified and these are being dealt with differently, then overall the perinatal leadership team should select the RAG rating which best describes the safety issue(s) with the highest risk.

Question	Answer
How would you summarise the outcome of this critical safety check (drill version)?	AMBER/RED - there is at least one known safety issue in our intrapartum service, but a plan of action is not in place

Section 5 – recommendation from this critical safety check (drill version)

It is recommended that the below actions are taken following the relevant conclusion of this check from section 4.

Conclusion	Action(s)	Please select
GREEN – no safety issues in our intrapartum service have been identified	no action is required other than sharing the completed check with ICB (executive with responsibility for maternity and neonatal services and director of quality) and regional colleagues (regional chief nurse, midwife, obstetrician and medical director) for awareness	☐
GREEN/AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) - the perinatal leadership team should continue to report to the trust board on plans as required - the trust board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed	☐
AMBER - there is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures). - an urgent discussion between the perinatal leadership team and the trust board is required within 4 weeks with an agreement get plans back on track within 12 weeks - the trust board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed	☐
AMBER/RED - there is at least one known safety issue in our intrapartum service, but a plan of action is not in place	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) - an urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks - the trust board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed	☒

RED – at least one new safety issue in our intrapartum service has been identified which requires a plan of action	- the completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note in section 4 of the standard operating procedures) - an urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks - the trust board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed	☐
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DATE:17/08/2026

AGREED BY MEMBERS OF THE PERINATAL LEADERSHIP TEAM AND TRUST BOARD EXECUTIVE(S) AS FOLLOWS:

NAME(S)	ROLE(S)
<i>Emma Ashton</i>	Divisional Midwifery and Nursing Director
<i>Lauren Murphy</i>	Interim Clinical Director for Obstetrics & Gynaecology
<i>Russell Dineley</i>	Divisional Director
<i>Steve Canty</i>	Chief Medical Officer

Action Plan – MOSS Drill 17 August 2026

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
Lead Officer:	Divisional Midwifery and Nursing Director

Status Key	
1	Not complete
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Version	Date
V1	10.09.2026

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status			
						1	2	3	4
1	Caesarean section decision to delivery improvement Aim: Achieve: ≥90% Category 1 Caesarean Sections within 30 minutes ≥90% Category 2 Caesarean Sections within 75 minutes	Undertake retrospective review of all Category 1 & 2 delays from previous 6 months	Audit midwife	31/10/26					
		Identify delay themes (theatre access, transfer delays, anaesthetic availability, staffing, neonatal attendance, documentation)	Audit midwife / Matron for Complex Care	31/10/26					
		Review data quality issues so that these are understood and can be addressed	IT midwife	31/10/26					
		Include monthly SPC charts to Divisional, Safety & Quality Committee's and Board	Clinical Director	31/10/26					
		Conduct simulation training focused on emergency theatre pathways	Practice educator	31/12/26					
		Communication across midwifery, obstetric and theatre teams to raise awareness and share learning	Governance lead	31/10/26					
2	Induction of labour (IOL) Flow improvement Aim: Increase IOL commencement	Review current IOL pathway and patient flow to ensure planning in relation to service acuity	Matron for complex care	31/10/26					
		Review outpatient induction of labour offer to ensure that women who meet the criteria are receiving this offer as standard practice	Matron for complex care	31/10/26					

	within 6 hours from 57% to >85%	Review escalation pathway for women where induction of labour is delayed	Matron for complex care	31/10/26		
		Review data quality issues so these are understood and addressed	IT midwife	31/10/26		
		Implement real-time dashboard for waiting women	Maternity A Ward Manager	30/11/26		
		Complete workforce review of IOL staffing model as part of the wider staffing remodel	DMND	31/12/26		
		Introduce weekly oversight until sustained improvement achieved	DMND	31/10/26		
3	MDT communication Aim: Improve multidisciplinary situational awareness and escalation effectiveness.	Revise safety huddle SOP	Deputy DMND	31/10/26		
		Mandate attendance by consultant obstetrician and anaesthetic representative	Clinical Director	31/10/26		
		Monitor compliance with attendance and escalation actions	Matrons	31/12/26		
4	Equipment, Estate and Digital Aim: Address staff concerns regarding environment and equipment availability.	Complete equipment gap analysis	Matrons	31/10/26		
		Once gap analysis has been undertaken consider funding opportunities and whether a business case is required	DMND	31/11/26		
		Review CTG equipment availability within theatres	Matron for complex care	31/10/26		
5	Transitional Care and Postnatal Capacity Aim: Improve capacity and reduce workload pressures.	Review Transitional Care demand and capacity model to inform planning and financial considerations	Neonatal Transitional Care Lead	31/10/26		
6	Service user experience and Health inequalities	Perinatal service to participate in the PEADP programme	Divisional Director	31/12/27		
		Review MNVP arrangements	Deputy DMND	31/10/26		
		Review inclusivity of maternity environments and information	Consultant Midwife	31/11/26		

