NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PART I MEETING - 5 DEC 2024

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5 December 2024

12:45 GMT Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

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PATIENT STORY : CHILDREN AND YOUNG PEOPLE TEAM

Information Item | Dr D Kendall | 12:45

AGENDA

REFERENCES

Only PDFs are attached

Agenda - Board (part I) - 5 Dec 24.pdf

Board of Directors

5 December 2024 | 1.00pm | Lecture Room 1, Education Centre 1, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancashire, PR2 9HT

Agenda

At 12.45pm, there will be a **Patient Story** presented by members of the Children and Young People Division

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P White
2.	Apologies for absence	1.01pm	Verbal	Information	P White
3.	Declaration of interests	1.02pm	Verbal	Information	P White
4.	Minutes of the previous meeting held on 3 October 2024	1.03pm	✓	Decision	P White
5.	Matters arising and action log update	1.04pm	✓	Decision	P White
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P White
7.	Chief Executive's report	1.10pm (10mins: Q&A)	✓	Information	S Nicholls
8.	Revised Board Assurance Framework	1.20pm (20mins: Disc)	✓	Decision	S Regan
9.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
9.1	Safety and Quality Committee Chair's Report	1.40pm (10mins: Q&A)	✓	Assurance	K Smyth
9.2	Maternity and Neonatal Services Report	1.50pm (10mins: Q&A)	✓	Assurance	J Lambert
10.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
10.1	Workforce Committee Chair's Report	2.00pm (10mins: Q&A)	✓	Assurance	V Crorken
10.2	Education, Training and Research Committee Chair's Report	2.10pm (10mins: Q&A)	✓	Assurance	P O'Neill
11.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
11.1	Finance and Performance Committee Chair's Report	2.20pm (10mins: Q&A)	✓	Assurance	T Whiteside
11.2	Integrated Performance Report as at 31 October 2024 including Finance update and Single Improvement Plan *(considered by appropriate Committees of the Board)*	2.30pm (10mins: Pres) (10mins Q&A)	✓	Assurance	K Foster-Greenwood/ S Cullen/ N Pease/ D Stonehouse
12.	**GOVERNANCE AND COMPLIANCE**				
12.1	Annual Health and Safety Review Report	2.50pm (10mins: Q&A)	✓	Assurance	S Cullen
12.2	Revision to Board of Directors Committee Terms of Reference	3.00pm (5mins: Pres)	✓	Decision	J Foote

№	Item	Time	Encl.	Purpose	Presenter
13.	**ITEMS FOR INFORMATION**				
13.1	(a) Emergency Preparedness Resilience and Response (EPRR) Core Standards 2024-25		✓		
13.2	Date, time and venue of next meeting: *6 February 2025, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	3.05pm	Verbal	Information	P White

1. CHAIR AND QUORUM

Information Item | P White | 13:00

2. APOLOGIES FOR ABSENCE

Information Item | P White | 13:01

3. DECLARATION OF INTERESTS

Information Item | P White | 13:02

4. MINUTES OF THE PREVIOUS MEETING HELD ON 3 OCTOBER 2024

Decision Item | P White | 13:03

REFERENCES

Only PDFs are attached

04.0 - Minutes - Board (Part I) - 3 Oct 24.pdf

Board of Directors

3 October 2024 | 1.00pm
Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

Present:

Mr P White	Chair
Dr T Ballard	Non-Executive Director
Ms V Crorken	Non-Executive Director
Ms S Cullen	Chief Nursing Officer
Ms K Foster-Greenwood	Chief Operating Officer
Professor S Nicholls	Chief Executive
Professor P O'Neill	Non-Executive Director
Dr G Skailes	Chief Medical Officer
Mr D Stonehouse	Interim Chief Finance Officer
Mr T Watkinson	Non-Executive Director

In attendance:

Mrs K Brewin	Associate Company Secretary *(minutes)*
Mrs A Brotherton	Director of Research and Continuous Improvement
Ms G Clarkson	Radiotherapy Service Manager *(patient story)*
Mr G Doherty	Director of Strategy and Planning
Mrs N Duggan	Director of Communications and Engagement
Mrs L Elliott	Divisional Director of Nursing (Surgery) *(patient story)*
Mrs J Foote	Director of Corporate Affairs
Ms J Lambert	Interim Divisional Nursing and Midwifery Director *(minute 162/24)*
Ms L Laws	Principal Therapeutic Radiographer *(patient story)*
Mr N Pease	Chief People Officer
Mr S Regan	Associate Director Risk and Assurance *(minute 160/24)*

Governors observing: Margaret France, Janet Miller, Frank Robinson, Mike Simpson, Christine Pownall, Nigel Garratt

Observers: Raj Purewal, C2-Ai

Prior to the Meeting the Board received the Following Presentation: Patient Story, Surface Guided Radiotherapy at Rosemere Cancer Centre

Representatives from the Division of Surgery were joined by the patient, Rachel, who was undergoing treatment for breast cancer and had experienced the new surface guided radiotherapy technology (SGRT) that the Rosemere charity had supported purchasing. SGRT enabled treatment without the need for any permanent tattoo or markings using thousands of points of infrared light over the actual treatment area and was completely non-invasive, was proven to be more accurate, and ensured the patient was not left with a permanent reminder of their cancer experience which could psychologically affect some patients. The patient described their improved experience from SGRT intervention and the positive psychological effects.

In response to a question from the Board regarding whether the patient had any suggestions about things that could be improved, it was confirmed that there was nothing that could be suggested in relation to the service provided. The patient confirmed that there was a positive relationship with the team where she felt comfortable raising questions and if there was a need for the advice to be repeated then the patient could ring the team and advice was also followed up in writing.

The Board recognised the Rosemere Cancer charity and their kind donation to allow purchase of the technology. It was encouraged to hear throughout the presentation the information provided regarding the improved patient experience which had supported the bids for funding.

The Board recognised the powerful patient story particularly the improvement in the patient experience and the profound effect it had on the patient to maintain their dignity, ensure they felt respected, and consideration of what mattered as a person not merely a patient. Rachel was thanked for attending the Board and presenting her experience so Board members could better understand the differences that could be made through the introduction of such technology.

153/24 Chair and quorum

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

154/24 Apologies for absence

Apologies for absence were received from Mr U Patel, Ms K Smyth, Mrs T Whiteside.

155/24 Declaration of interests

There were no conflicts of interest declared by the Board in respect of the business to be transacted during the meeting save for the following:

The Chair made a general declaration in respect of his role as Chair of the North West Ambulance Service.

156/24 Minutes of the previous meeting

The minutes of the meeting held on 1 August 2024 were approved as a true and accurate record subject to the amendment to minute 127/24, Maternity and Neonatal Services Report, second paragraph, second sentence to read annual (rather than bi-annual) safe staffing report.

157/24 Matters arising and action log

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

158/24 Chair's report

The report provided a summary of work and activities undertaken during August and September 2024 by the Trust Chair including a resume of the items discussed in the part II Board meeting in August.

The Chair confirmed that he had declared his intention to step away from the role as chair no later than 31 March 2025. This was to allow for a new permanent chair to be

appointed and in place in advance of the requirement for new appointments for non-executive board directors to be made during the year under the leadership of a new chair. The Chair was thanked for his commitment and leadership of the Trust during a difficult period. The Board wished him well for the future.

Board was reminded of the review being undertaken by the government into the New Hospitals Programme. The Darzi report had referred to the condition of hospital infrastructures in terms of crumbling estates, lack of investment and other issues affecting the NHS which it was hoped would influence and support the Trust's business case for a new hospital. Reference was made to the patient story and the innovative care and treatment being provided in the Trust and staff were acknowledged for their commitment to provide the best services they could for patients.

A summary was provided of the Annual Members Meeting (AMM) on 26 September and whilst attendance has been low there was an opportunity to build on the experience when planning for next year. The Chair thanked all those involved in ensuring the AMM was a successful event.

159/24 Chief Executive's report

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

Darzi Report – the need to invest in diagnostics and earlier intervention for patients was a key issue within the report and the Trust's 5-year Strategy was included on the agenda (item 12.2). The main challenge for the Trust was the financial position which was receiving significant focus by the Executive Management team including the need to take short-term decisions to control expenditure and further steps would be introduced in relation to vacancy control and variable pay spend. The Chief Executive would be attending an event on 4 October with the Secretary of State for Health and Social Care where it was anticipated insights would be shared into what the government would be doing in terms of outputs from the Darzi Report.

New Hospitals Programme – the Trust was expecting to receive the outcome of the New Hospitals Programme Review at the end of December or early January which it was anticipated would be about changes to the timescales rather than cancelling the programme. It was acknowledged that the Trust had strong political support for its business case for a new hospital.

Interim Chief Finance Officer – David Stonehouse was welcomed to his first Board meeting and it was confirmed that interviews would be taking place on 7 October for a permanent Chief Finance Officer.

Acute Medical Assessment Unit – the new Acute Medical Assessment Unit (AMU) officially opened at Royal Preston Hospital on 23 September. The AMU was a 24-bedded space which included two assessment bays and 10 side rooms. The facility would assist with pulling patients from the Emergency Department with the aim to improve patient experience, length of stay, admission avoidance and performance within the Emergency Department.

Reference was made to the emphasis placed on engagement with staff within the Darzi Report specifically highlighting that staff were disinclined to go the extra mile therefore

clarification was requested on how staff would be engaged to support that ambition and increase productivity. It was explained that one element would be to determine a structured process to engage with staff on improvement. When organisations were under pressure financially and operationally it was sometimes possible to miss what must be done. The Trust had a programme of staff team briefs, leadership forums, and increased visibility from Executive Directors on walkabouts who visited wards and departments to talk to staff and patients. The message being delivered was honest and transparent which would be key to ensure all were aware of the challenge. It was recognised that additional controls had been introduced recently in respect of vacancies and the message had been realistic in terms of the timescale for the changes.

A question was raised regarding how successful research programmes were embedded within the Trust to achieve value particularly as the Trust was under financial constraints. It was confirmed that such programmes aligned to a robust business planning process recognising that resources were scarce. If it was not possible to support a development then plans would be held to pull through when additional funding was identified or available.

160/24 Board Assurance Framework

The report provided details of risks that might compromise the achievement of the Trust's high level strategic objectives. The strategic risks detailed in appendix 2 were those that had been presented to Committees for scrutiny or had been reviewed in preparation for the next Committee meeting at the time the Board report was produced. It was confirmed that there had been no changes to the six strategic risk scores since the August Board meeting and three operational risks remained escalated to the Board relating to exit block (risk ID25); elective restoration (risk ID1125); and *C.difficile* infection (risk ID1157). The Board Assurance Framework was currently under review to align to the new Trust Strategy which would be available later in the year.

Board members acknowledged the opening of the AMU and requested clarification on when it was expected that improvements would be seen in the Emergency Department and risk ID 25 as a result. It was explained that the Trust was entering the winter period and there was a gap of 60-70 beds in the current bed estate. The team had opened the new AMU and were facing challenges with rolling out a new department on an old pathway therefore tests of change were being completed on a daily basis. Proceeding through winter and exiting out there would be opportunities from the new model to potentially reduce the number of beds as people would return to their place of residence more rapidly. It was expected that a winter surge would be seen although the new AMU would provide the opportunities to better manage winter.

The Board RESOLVED that the updates to the Board Assurance Framework be approved.

161/24 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee provided an overview of items discussed at the meetings on 26 July and 30 August 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Board was alerted to non-compliance with national cleaning standards which had been partially implemented some of which were in high or very high-risk areas. The Committee was concerned that in very high-risk areas the Trust was below cleaning frequency and in high-risk areas the Trust was well below trajectory. A continuing concern had been raised with Board regarding *C.difficile* infection rates and evidence was available to show that where cleaning standards had been introduced there had been reductions in infection rates. It was recognised that there would be a cost implication to bring compliance in line and the Committee had sought assurance that as part of planning for 2025-26 the target for cleaning standards would need to be as close as possible to the 2021-22 trajectory.

Board members acknowledged the financial constraints however felt that cleanliness would be something that patients would always expect to see in hospitals. In terms of the high and very high-risk areas where compliance was below expected levels it was confirmed that at the start of the year different cleaning practices were introduced to attempt to mitigate the position. With regard to the investment required this would need to be part of the business planning process for 2025-26. It was acknowledged that there was no additional funding from commissioners or other NHS funding sources and work would continue to improve the position within existing resources.

Reference was made to the results of the national Picker Inpatient Survey which identified that improvement was required in a range of areas. In response to a question regarding whether the survey results would be presented, it was confirmed that the results would be part of an overarching patient experience report to Board.

The Committee noted that the target audience for sepsis training had been extended and compliance was not yet at the required standard. It was noted there was a need to identify and record how and when doctors in training with the Trust had received sepsis training. The Board was advised that the matter had been escalated to the Training team at Health Education England as all resident doctors had not received sepsis training and the Trust had been advised that it should not be included as a mandatory module: the Trust was continuing to progress the matter on this important topic.

As a general point in relation to the 3As Committee Chair's report, it was noted that some further work was required on where items were placed within each section recognising that this was a relatively new format and work in progress.

162/24 Maternity Service Annual Staffing Review

The report outlined the findings of the annual maternity staffing review and an overview of the contents was provided. It was noted the report had been scrutinised and endorsed by the Safety and Quality Committee for approval by the Board. Overall, the establishment recommended by the Interim Divisional Midwifery and Nursing Director and the Chief Nursing Officer as part of the review would deliver safe, effective and sustainable staffing levels for the Trust and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016).

The Non-Executive Director Maternity Safety Champion advised of a visit to the maternity ward and the opportunity to speak to staff, and on behalf of the Board passed his congratulations to the midwives shortlisted for two Royal College of Midwives national awards to recognise (a) Outstanding Contribution to Midwifery Services:

Pregnancy Loss and Bereavement Care; and (b) Outstanding Contribution to Midwifery Services: Improving Safety and Quality of Care.

It was noted that improvements in some of the metrics relating to safer care (such as one-to-one attendance with continuity of care for women in labour) and the link between safe staffing and outcomes/risk could not be overemphasised. The team had performed well to manage the outcome of risk although there were markers in terms of balancing finances and the uplift in staff, and a need to bear in mind the significant indemnity costs that could be paid when things go wrong. However, overall the report was positive.

Since the report had been produced the CQC had published its national maternity statement and an area of focus for risk was improvement and standardising triage and clarification was requested on whether the work being undertaken in the Trust would comply with CQC requirements. It was confirmed that the team was focused on the national position and partial implementation last year against the standard had helped, and further investment in staffing would improve the position further.

The Board RESOLVED that:

1. **the maternity safe staffing review phase 2 investment be approved which would form part of the 2025/26 financial plan; and**
2. **the Perinatal Quality Surveillance Dashboard and CNST supplementation information as part of the Maternity Incentive Scheme requirements for year 6 be noted.**

163/24 Mid-year Safe Staffing Review for Nursing

The report provided details of the mid-year safe staffing review for nursing. It was noted the report had been scrutinised and endorsed by the Safety and Quality Committee for approval by the Board. Overall, the establishments recommended by the Chief Nursing Officer as part of the review would deliver safe, effective and sustainable staffing levels for the Trust and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016).

The Board RESOLVED that:

1. **the mid-year safe staffing review for nursing be approved;**
2. **the approach to managing safety in the Emergency Department be supported; and**
3. **it was satisfied of the assurances outlined within the report.**

164/24 Workforce Committee Chair's report

The Chair's report from the Workforce Committee provided an overview of items discussed at the meetings on 10 September 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The main issue for the Committee related to medical staffing and the lack of senior cover for FY1 doctors at Chorley and South Ribble Hospital along with negative feedback on cultural issues which had been raised within the GMC survey. Assurance had been requested on the interventions and actions being introduced to support and address the issues.

In terms of the results of the GMC survey, poor performance had been identified some of which related to cultural issues within departments and/or specialties, and the impact that this not only had on patient care but also in terms of the satisfaction level of doctors in training. The Board discussed medical staffing to patient ratio and whether it would be helpful for one Committee to monitor the position rather than the current approach of Committees considering different information in isolation as there had been consistent themes on the issues raised, some of which were recognised as being complex. Board members agreed that it would be helpful for a piece of work to be undertaken to gather the information in one place to provide assurance on the current position, the direction of travel, and where things would be in the future. It was noted that work had commenced to review a range of elements, including staffing levels, and it was suggested that the report once produced should be presented to and monitored by the Workforce Committee.

An assurance report would be produced by the Chief People Officer recognising the themes straddled a range of Committees (for example, training statistics, staffing levels, controls, doctors in training, supervision, etc.). Committee Chairs agreed to email the Chief People Officer to clarify the assurance the Workforce Committee would be looking for.

165/24 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee provided an overview of items discussed at the meeting on 13 August and 5 September 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Committee undertook the annual education contract reviews with clinical divisions and received limited assurance due to the late receipt of some information for the meeting and the absence of one team who did not attend.

The Committee discussed mandatory training and the levers brought to bear should people not meet compliance with training rates. It was noted that evidence and assurance had been provided in Divisional Improvement Forums to show that mandatory training levels were improving.

As a general point, the important role of assurance Committees was emphasised by the Board along with the need for presenters to attend meetings and ensure information was submitted in a timely manner for due consideration prior to meetings.

166/24 Charitable Funds Committee Chair's report

The Chair's report from the Charitable Funds Committee provided an overview of items discussed at the meeting on 17 September 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The positive and strong financial performance of the charities was acknowledged. However, the Board was alerted to the unintended consequences of the current financial controls introduced by the Trust on the charities' operations particularly where vacancies were not being filled meaning it was not possible to take forward some bids.

The Chair recognised the strength of the charities and acknowledged the generosity of donators. A discussion had been held with the Chair of the Rosemere Cancer Foundation and a patient story would be arranged at a future date to outline the work of the charity and how the Trust had benefitted from its generosity.

167/24 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee provided an overview of items discussed at the meetings on 23 July and 27 August 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

There was a lack of pace in terms of service line reporting to show what was driving the deficit and more focussed concentration was required to clearly identify those costs. The Trust's finances were off track at month 5 and there was a risk for the remainder of the financial year therefore a significant challenge was faced in respect of achieving the target by the end of March 2025. There had been a step change in terms of plans for financial recovery with additional rigour introduced in the last three months. There had been some improvement in operational funds in some key areas although it was acknowledged there continued to be significant pressures in particular areas, such as the Emergency Department, diagnostics, and outpatients. However, each of the areas had been reviewed and the Committee was assured regarding their plans to address and recover in those areas.

Some encouraging work had been undertaken on business planning which was now more thoughtful in terms of processes that needed to be introduced. The Committee received assurance on the Trust's Emergency Preparedness, Resilience and Response core standards for 2024/25 and approved the submission to the Integrated Care Board.

168/24 Integrated Performance Report as of 31 August 2024

The integrated performance report as of 31 August 2024 provided an overview of key performance indicators. The report content and structure had been updated to reflect the metrics agreed as part of the Trust's Single Improvement Plan (SIP) and the SIP Board format. Detailed scrutiny of the metrics was undertaken by respective Committees of the Board. Key messages were highlighted from each of the main ambitions in addition to those already reported during the meeting by respective Committee Chairs.

(a) ***Consistently Deliver Excellent Care*** – improvements had been seen throughout August in the 4-hour emergency care standard including improvements in ambulance handover times, reductions in boarded patients and overcrowding in the Emergency Department. However, the department remained under pressure in relation to long-stay patients in the department. Work was being undertaken in relation to patients not meeting the criteria to reside to analyse the days as opposed to the number of patients to drive the work through the system-wide delivery plan. There had been a continued reduction in long-waits and the latest position showed there had been only five patient breaches at the end of September all of which were outside of the Trust's control. Performance against the 65-week wait target remained a challenge when trying to balance performance with the finances. It was

noted that cancer performance overall was solid and all trajectories had been achieved during the month, although there remained tumour groups where there were fragilities: the position was being closely monitored and the team was working through mitigations. The Trust was a significant outlier in terms of diagnostic performance and work was being undertaken through the Diagnostics Management Group to analyse the metrics, capacity and demand, and ensure best use of sparse resources.

Reference was made to the theatre utilisation rates particularly at Chorley and South Ribble Hospital which was a national elective centre. Board members noted that activity appeared to be plateauing and requested clarification on how increased activity was delivered making best use of that resource. An outline was provided of the 6-4-2 theatre planning process[1] and the team had also introduced on-the-day scheduling. However, the complexity of patients and day-to-day operational factors would always play a crucial part in full utilisation of such facilities.

In response to a question regarding the plan for the fragile cancer tumour sites and whether it was anticipated there would be an increase in performance, it was confirmed that an internal stretch trajectory had been agreed for delivery before next year's targets had been identified. There were differences between tumour groups and percentages did not fully describe what was trying to be achieved.

In respect of the safety and quality metrics it was confirmed that positive fill rates had been seen due to utilisation of bank staff. There had been a consistent reduction in complaints as a result of sustained focus on local resolution and a similar position had been seen in the friends and family test responses. Implementation of the refreshed Safety Triangulation Accreditation System (STAR) process was well underway which now included some CQC mandatory standards that mirrored areas consistently underachieving. It was noted the refreshed STAR process would negatively impact the outcomes within STAR until embedded with the aim of leading to an improvement. In August the 2024-25 objective for *C.difficile* had been confirmed by NHS England and an increase had been seen from 122 to a maximum of 199 cases, in recognition of the national increase in infection rates following the pandemic. In respect of the CQC Inspection recommendations, the Trust had delivered 50 out of 75 actions and had plans in place to deliver the remaining 25 actions.

(b) ***Great Place to Work*** – sickness absence levels had exceeded 6% during the reporting period despite the amount of work undertaken during the year and, in the main, the reasons for absence related to mental health conditions. The internal auditors (Mersey Internal Audit Agency) had undertaken an audit of the Trust's absence management process and the report would be presented to the Audit Committee in due course. However, the team was working on delivering the recommendations outlined in the report and would be introducing a pilot to focus on the highest areas where sickness occurred. Vacancy rates had increased which in part was due to the vacancy firebreak and lots of work was being completed on the impact of holding vacancies to ensure that service quality was not adversely affected. In respect of agency usage and bank spend, September had been a

[1] 6-4-2 Theatre Planning Process: At six weeks, surgical staff should have their annual leave approved. At four weeks, surgeons should have scheduled their theatre lists. Two weeks ahead of time, theatre plans should be reviewed, finalised and there should be no further changes made from this point onwards.

challenging month with the annual influx of staff, such as doctors on rotation and nursing students, and conversely University students leaving the Trust following their training. It was noted that the medical bank (Medacs) had been repatriated and would now be operated by the Trust: the service went live on Tuesday, 1 October.

Clarification was requested on whether a budget had been allocated to provide psychological support for staff and whether evidence was available that investment in such support would help with pay back and reduce sickness levels. An example was provided from a previous organisation where psychological support had been introduced in maternity which did evidence improvements. It was confirmed that this Trust had invested strongly in staff psychological support and it may be helpful to look at maternity staff in this Trust to see what additionally could be introduced.

(c) ***Deliver Value for Money*** – the Trust continued to have a considerable underlying financial pressure to manage and a financial recovery plan (FRP) target of £58m to deliver. It was noted that the most recent position on the FRP showed the plan was off track by £1.2m. The cash position remained challenging and the cash support application in September had been approved with a £10m draw down by the Trust.

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

169/24 Single Improvement Plan

The report provided an update on the implementation of the Single Improvement Plan (SIP) and an overview of the current position was provided for information. Work had been undertaken on the report to align improvement and operational activities and the report structure was transitioning from the previous reporting style to an action and risk-focused report.

Operational performance was a key focus at present and the Finance and Performance Committee had drilled down on the information in recent meetings. To strengthen grip and control around the Trust's finances the Executive Management team had introduced daily pay and non-pay review groups.

Attention was drawn to the risk relating to the Programme Management Office and a business case would be developed for additional support. A significant demand was being placed on the Business Intelligence team with increasing requests for data reporting and consideration would be given to ensuring the team was right-sized to deliver on the demands across the organisation.

In response to a question regarding the focused work on urgent and emergency care and the progress that had been made, it was noted that a meeting was being arranged with the Finance and Performance Committee Chair to walk through the plans and the methodology to be used.

In terms of the report structure, the Chair acknowledged that the narrative was good and reader-friendly and discussions would be held with the Director of Continuous

Improvement and Research regarding how the visual graphics could be enhanced to help with understanding.

The Board CONFIRMED it was assured of the progress being made on the Single Improvement Plan.

170/24 Trust Strategy 2025-30

The draft 5-year Trust Strategy had been circulated for consideration. The strategy remained a work in progress and following refinements over the next couple of months it was intended to present the final version for approval by the Board in December. Board members were feeding helpful suggestions into the style and structure of the report and, where possible, Committees would have time before the December Board meeting to look through the document. During discussion the following observations were noted which would be picked up in the final strategy:

- There were some elements of the strategy outwith the Trust's control, such as a cleaner Lancashire and South Cumbria, therefore there was a need to ensure that the strategy included matters that were within the Trust's capability to deliver.
- Some of the narrative related to the current state and in future years when judging the impact of the strategy there may be more about population growth and challenge that should be included, in addition to longer term measures of success and ambition.
- It was observed that from a lay person point of view some of the narrative was quite technical or NHS-specific therefore an easy-reference version would need to be considered for the general audience. Consideration could be given to testing the draft strategy with a selection of the local population including the language used in the document.
- There was a need to step back and reflect on some of the wording to ensure the strategy aligned to the purpose of the Trust. As an example, 'wealth' as opposed to 'wellbeing' was used throughout the document and the Trust's purpose would need to be clear to ensure there was no confusion.
- The outputs from the system report produced by Strasys would be reaching a point where it could feed into the near-term strategy for the Trust. There were also ongoing discussions regarding whether it was more appropriate to create a 10-year rather than a 5-year strategy.

Any further feedback would be emailed to the Director of Strategy and Planning.

171/24 Audit Committee Chair's report

The Chair's report from the Audit Committee provided an overview of items discussed at the meeting on 19 September 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Committee remained concerned regarding the number of single tender waivers where tendering processes had not been applied. In addition there had been delays in receiving final version internal audit reports in some critical areas and improvements would be made to the sign-off processes within the Trust. The Committee recognised there was robust recordkeeping in terms of implementing internal audit recommendations although there had been occasions when the implementation date for agreed actions had been changed without the Committee being sighted. Therefore, the

Committee had requested greater oversight when deadlines for implementation had been extended. The Committee received positive assurance in relation to cyber security processes and controls.

In terms of internal sign-off processes for final version internal audit reports, it was explained that greater scrutiny and factual accuracy checks by Executive leads had been introduced which in some cases had delayed finalisation of the reports prior to the September Audit Committee meeting. A piece of work had been introduced to map timings of final audit reports to ensure the Executive Management team scrutinised the contents prior to sign-off to ensure that timescales aligned for submitting the reports to the Audit Committee by the deadlines for receipt of reports.

With regard to single tender waivers, it would be important to understand where the challenges lay, i.e. whether the matter related solely to Trust processes or whether the Procurement team did not have the capacity to progress the tendering process. There was a need to ensure single tender waivers were only used in exceptional circumstances and move away from excessive levels of waiver applications.

172/24 Oversight and Accountability Framework

The report provided an overview of the work undertaken to develop a new Oversight and Accountability Framework for the Trust. The report also outlined the next steps needed to support implementation, including populating the assessments and allocating ratings (levels 1-4); testing the new framework and plan for the Divisional and Corporate Improvement Forums (DIFs), assessing improvement maturity across the organisation in line with the NHS IMPACT framework; and undertaking a review of the final version of the NHS England Oversight and Assessment Framework when published to ensure that the Trust was able to undertake and submit the anticipated quarterly self-assessments in line with anticipated national requirements.

Approval of the Board was sought to progress the policy for ratification of the Oversight and Accountability Framework and to test the new processes for the DIFs. It was noted that the Oversight and Accountability Framework had been submitted to the ICB and NHSE for comment and had also been presented to the newly constituted Trust Management Board.

The Board RESOLVED that the new Oversight and Accountability Framework and policy be approved to progress through to the Policy Ratification Committee.

173/24 Establishment of Trust Management Board

The report outlined the proposals for a new Trust Management Board comprising members of the executive and senior leaders and acting as the highest decision-making authority at a management level within the Trust.

Clarification was requested in terms of the framing and opportunity for the Trust Management Board to act with delegated authority and whether safeguards were required to be introduced. It was agreed that the terms of reference would be amended to include appropriate wording in this regard.

The Board RESOLVED that:

1. **the establishment of a formal Trust Management Board together with the terms of reference set out in the report be approved following the addition of appropriate wording around decisions made by the Trust Management Board;**
2. **the authority granted in the terms of reference as an amendment to the Scheme of Reservation and Delegation (pending the inclusion of the requirements in a later planned revision) be recognised; and**
3. **the associated terms of reference of the Executive Management Team be noted.**

174/24 Items for information

The following reports were received and noted for information:

(a) Allied Health Professionals (AHP) Safe Staffing Report
(b) Data Quality Assurance Report

175/24 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 5 December 2024 at 1.00pm in Lecture Room 1, Education Centre 1, Royal Preston Hospital.

Signed: _____
Chair

Date: _____

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | P White | 13:04

REFERENCES

Only PDFs are attached

05.0 - Action log - Board (part I) - 3 Oct 24.pdf

Action log: Board of Directors (part I) – 3 October 2024

No outstanding actions.

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	165/24	3 Oct 2024	***GMC survey themes*** – Committee Chairs to email the Chief People Officer to outline what they would want to see included in the overarching report to the Workforce Committee to provide the required assurance.	Chief People Officer	5 Dec 2024	**Completed** **Update for 5 December 2024** – email sent to Committee Chairs on 15 October requesting responses to the Chief People Officer.
2.	174/24	3 Oct 2024	***Trust Management Board Terms of Reference*** – to be amended to include clarification around decisions made by the Trust Management Board.	Director of Corporate Affairs	5 Dec 2024	**Completed** **Update for 5 December 2024** – terms of reference amended on 4 October 2024.
3.	167/24	3 Oct 2024	***Patient Story: Rosemere Cancer Centre*** – patient story to be arranged at a future date to outline the work of the charity and how the Trust had benefitted from its generosity.	Chief Nursing Officer	To be confirmed	**Completed** **Update for 5 December 2024 -** Patient story at Board regarding precision point technology at the last meeting demonstrated the investment from charity.

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | P White | 13:05

REFERENCES

Only PDFs are attached

06.0 - Chair's Report - 5th Dec 24.pdf

Board of Directors Report

Chair's Report			
Report to:	Board of Directors	**Date:**	5th December 2024
Report of:	Chair of the Trust	**Prepared by:**	Rebecca Black System Collaborative Business Manager to CEO
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

Chair's Report

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during October and November.

2. Ward and Department Visits

During October and November I have had the opportunity to walk around the Trust and visit departments and talk to teams. Staff are all working extremely hard to deliver excellent services to our patients and it really is a team effort across the organisation. Departments I visited include Ribblesdale; Ward 19 and the Respiratory ward.

3. Incoming Chair – Professor Mike Thomas

I am delighted to report that Professor Mike Thomas has been appointed as my replacement in January 2025 following a competitive interview process involving members of the ICB, NHS England, colleagues and governors. Whilst I will be sorry to leave this organisation, I am confident that Mike, with support from the Trust Board, will enable the Trust to achieve its full potential as we undertake a transformation of our system wide clinical and community services.

4. Part II Board of Directors' meetings – October 2024

The items discussed at the part II Board meeting on 3rd October and the Special part 11 Board meeting on the 29th October are outlined below along with a brief resume of the discussions.

3 October 2024

1. One LSC: Business Transfer Agreement and Supply Agreement – the Board considered the up-to-date documents and had the opportunity to feedback and request clarification on any outstanding issues.
2. Pathology Collaborative – an update was received on the business case and work being undertaken to develop a single service across the system as mandated by NHS England.
3. Financial Recovery: Investigation and Intervention Report – a report was received providing an update on the risk-based financial forecast and the improvement workstreams being taken forward within the Trust as part of phase one of the investigation and intervention work across the Integrated Care Board.
4. Minutes of meetings – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

29 October 2024 – Special PII Board

1. One LSC – the Board approved the Business Transfer Agreement and Supply Agreement to enable One LSC to progress to commencement on 1 November 2024.
2. Financial Position Update – the Trust's financial performance for month 6 (September 2024) was scrutinised and discussed.

5. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during August and September 2024.

Date	Activity
October 2024	
2nd	Managing Director – LSC Provider Collaborative
2nd	Managing Director – One LSC
3rd	Board Pre-Meet
3rd	Board of Directors
7th	Chief Finance Officer Interview Process
8th	Chairs, Deputy Chairs and Lead Governor Meeting
10th	Provider Collaboration Board
11th	Awards Evening
12th	Non-Executive 121
16th	Chief Executive
22nd	Non-Executive 121
22nd	121 Place Lead
24th	Chair, University Hospital of Morecambe Bay
24th	Complaint Meeting
24th	Non-Executive Team Meeting
29th	Chief Nursing Officer
29th	Special Part 2 Board
30th	Board Workshop
31st	Chair, LSC ICB
November 2024	
5th	Non-Executive Monthly Meeting
7th	Turnaround Director
7th	Director of Corporate Affairs

7th	Council of Governors Public Meeting
28th	Chief Executive

6. Financial implications

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

7. Legal implications

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

8. Risks

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

9. Impact on stakeholders

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

10. Recommendations

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

7. CHIEF EXECUTIVE'S REPORT

Information Item | S Nicholls | 13:10

REFERENCES

Only PDFs are attached

07.0 - CEO Board report DEC 2024.pdf

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	5 December 2024
Report of:	Chief Executive	**Prepared by:**	N Duggan
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

Autumn Budget

The Autumn Budget, announced at the end of October by Chancellor Rachel Reeves, revealed that the NHS in England is to receive a £22.6bn cash injection over two years, in what she explained would be the biggest spending increase outside Covid since 2010. Ahead of the start of the Government's 10-year plan for the NHS,

in spring 2025, Reeves said the NHS was the nation's "most cherished public service" and that the extra funding would help the government cut waiting lists.

Overall, the Treasury said, the average annual increase to the day-to-day NHS in England budget was 4%, while the total increase for the Department of Health and Social Care (DHSC) was 3.4%.

Reeves also announced a "record" £3.1bn two-year increase in the department's capital budget, a 10.9% average annual rise. This includes £1bn for the repairs backlog and to tackle problems with reinforced autoclaved aerated concrete (Raac), £1.5bn of funding for new surgical hubs and diagnostic scanners and £70m for new radiotherapy machines.

Health experts welcomed the extra funding but cautioned that more investment in the NHS would be needed for patients to notice the difference.

Saffron Cordery, the Deputy Chief Executive of NHS Providers, said the budget brought a "welcome boost" for England's NHS trusts, but years of underinvestment and severe staff shortages meant all areas of the NHS were in a "very tough" position.

During the Chancellor's budget statement, a brief reference was made to the continuing work of the New Hospital Programme.

On 29 July 2024 the Chancellor announced a review of the New Hospital Programme (NHP) to ensure it had a 'thorough, realistic and costed timetable for delivery'. Both Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust NHP schemes were confirmed as within the scope of the review, as per the Terms of Reference published on 20 September 2024.

Getting our finances back on track

Ou workforce are our most valuable asset but also our most significant cost. At the end of October, we confirmed that a vacancy firebreak would continue until January 2025 and only posts that meet certain criteria will be considered by Vacancy Control Panel (VCP).

Posts that will continue to be recruited to include directly patient facing roles where there is a clinical safety risk, any member of staff involved in direct patient care, those directly engaged in the patient pathway, or those who provide a service that impacts the physical patient environment.

All non-clinical departments are required to refrain from using any overtime or bank until at least January 2025.

New Chair appointed

Since the last board meeting, Professor Mike Thomas has been appointed as the new Chair of our Trust Board. Currently Chair of University Hospitals of Morecambe Bay NHS Foundation Trust, Mike will take up his new position with effect from 1 January 2025. During this his five years of service at UHMBT, Mike oversaw significant improvements in terms of both operational and financial performance and brings with him a wealth of experience. Mike is also Lead Chair of the Lancashire and South Cumbria Provider Collaborative Board.

Mike has worked in academia and the health sector for nearly 40-years in a variety of senior academic roles, including Vice-Chancellor, also holding various professional chairs across four universities. He remains research active and a practising clinical psychotherapist.

Mike is committed to the voluntary, charity and public sector and is currently serving as Chair of Making Space, a national mental health charity and he co-founded the College for Military Veterans and the Emergency Services. Prior to entering academia, he served in the Royal Navy, working for five years in HM Submarines before employment in the engineering sector and then qualifying as a mental health nurse and later a psychological therapist.

Mike will replace our current Chair, Peter White, whose influence and impact has been notable both within the trust and across the system. This will be Peter's last board meeting, and I thank him again for his work since joining the Trust in August 2023.

Peter's knowledge, support, sense of humour and common-sense approach has been of great value to me, and I know that the entire Board and our Governors will join me in wishing him all the best.

Gary Doherty Director of Strategy to take up new role

Gary Doherty Director of Strategy is to leave the Trust at the end of the month to take up a new role as the Managing Director for the Provider Collaborative in Greater Manchester.

Gary has been with the Trust since 2020, initially in an interim capacity and he was then successful in securing the permanent role of Director of Strategy as part of a competitive process. Previously, Gary has held Chief Executive roles in Blackpool and Wales and has brought a great deal of experience and knowledge to the Board. He is also very skilled in developing positive relationships with partners and other stakeholders, something that will stand him in good stead in his new role.

In the spirit of our financial recovery programme, I will not be replacing the Director of Strategy role on a like for like basis but will be sharing the duties involved within the Executive team. As you know, Ailsa Brotherton has been leading much of the work on our new Single Improvement plan and agrees with me that the strategy portfolio is a good fit with this, alongside the Continuous Improvement work that she leads on.

Within LTH Gary leads on a number of areas such as the New Hospital Programme and Central Services so we will look at the best fit within other portfolios before allocating this work to individuals. Gary also leads on a number of system work programmes such as Elective Recovery and Digital Conversion, which will now be picked up the Provider Collaborative.

This is the second Board level role that we are giving up – I have not replaced the Director of IM&T role - so like the rest of the organisation we continue to play our part in developing different ways of working and opportunities for cost and head count reduction when they arise.

Gary is a very popular member of the Executive team and his integrity, sense of humour, enthusiasm and knowledge across a varied range of interests will be much missed.

I know you will join me in congratulating Gary on his new role and wish him every success in the future.

One LSC

It has been over two years since we set out our vision as a Provider Collaborative for the creation of a single vision for Corporate Services, now called Central Services, and we launched the One Lancashire and South Cumbria (One LSC) programme. One LSC, a large and complex change programme, will offer transformational opportunities as we move forward. Each of the five Trust Boards (Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust, and University Hospitals of Morecambe Bay NHS Foundation Trust) met and approved the necessary agreements to proceed with this new and innovative approach, which has been designed to put our corporate functions in a strong position in the future.

Friday 1 November was the transfer date, and a huge amount of work took place across our health system to make sure everything was ready for day one, with a very big thank you to everyone involved.

Kate Smyth listed in Shaw Trust Disability Power 100

It was great to see Trust Non-Executive Director Kate Smyth listed in the prestigious Shaw Trust Disability Power 100 2024, celebrated as one of the 100 most influential disabled individuals in the UK. The award ceremony was held at The Drum in Wembley, judged by a panel of 25 disabled champions including international business leader Dr Shani Dhanda, Chief Executive of Paralympics GB, David Clark and Coronation Street actor Cherylee Houston.

Testimonies described Kate as a transformative leader who has significantly advanced disability representation and advocacy across the NHS and beyond, and she has been recognised for her impact, innovation and influence in changing the perceptions and stereotypes of disability.

A NED at the Trust, Kate is also Co-Chair of the Disabled NHS Directors Network (DNDN) - which she helped set up in 2020, while she is a member of the Lancashire and South Cumbria ICB People Board, supporting the Belonging workstream, and Disability Advisor at the ICB.

Kate is also a Lay Leader at the Yorkshire and Humber Patient Safety Research Collaboration and a member of the Cabinet Office (Disability Unit) NW Regional Stakeholder Network, as well as a volunteer for Dogs for Good.

Through her leadership in DNDN, the network has helped to shape national NHS policies, champion inclusivity in recruitment practices, and launch mentoring and support initiatives for disabled leaders.

Kate's influence is far-reaching, helping impact national policy, local NHS Trusts, and individual lives, and her nomination was richly deserved.

It seems particularly fitting that this occurred during Disabled History month and colleagues are wearing purple in recognition of this and of International Day of Persons with Disabilities on 3 December. Buildings at Royal Preston have also been lit up purple and we have commemorated both occasions within our internal communications and on our digital screens.

National, Regional and Local Recognition

While it is important to highlight our key challenges, we must not lose sight of the incredible work and achievements of our colleagues which are being recognised on both a local and national level.

- **Trust opens 'gold-standard' regional Mohs surgery service for skin cancer patients**

It was great to hear about the Trust's plastic surgery department opening the first service in the region – and one of only a small number nationwide - offering the 'gold-standard' Mohs Micrographic Surgery and Plastic Surgical Reconstruction for NHS skin cancer patients.

Based at Chorley and South Ribble Hospital, the service offers patients with high-risk skin cancers in high-risk locations - such as the face, nose, ears, eyes and mouth - treatment with real-time histological analysis of the tumour and reconstruction of the wound, all in one sitting.

The main difference between Mohs surgery and conventional surgery is that histology – the microscopic study of tissues – is analysed in 'real-time' and results are available whilst patients are still at the hospital. Any remaining tumour can be completely removed, and the resulting defect reconstructed and repaired, in a single admission in the vast majority of cases.

The procedure aims to preserve as much normal skin and tissue as possible and has the highest cure rate (up to 99%) and lowest recurrence rates. It is classed as the 'gold-standard' treatment for removal of BCCs (Basal Cell Carcinoma) and some other skin cancers.

- **Trust collaborates with Manchester Metropolitan University on key hydrotherapy study**

I was pleased to hear that Lancashire Teaching Hospitals and Manchester Metropolitan University are collaborating to research the impact of, and help to unlock access to, hydrotherapy for boys and young men with Duchenne Muscular Dystrophy (DMD).

Having secured funding from Duchenne UK, the 24-month trial aims to demonstrate that hydrotherapy can benefit the mobility of DMD patients and help towards a better quality of life.

It is also hoped that the relationship between the Trust's Dr Christian de Goede, Consultant Paediatric Neurologist and Candiss Argent, Paediatric Research Physiotherapist, and Manchester Metropolitan University's Dr Christopher Morse, Reader in Exercise Physiology, will lead to further opportunities to work together.

Hydrotherapy is generally recommended for everyone with DMD; however, more evidence is required to show it benefits mobility. The cruel irony is, that the lack of evidence means there is a lack of provision across the UK for DMD patients to access hydrotherapy.

- **Wedding bells on Ribblesdale Ward at Royal Preston Hospital!**

It was sad but uplifting to hear of a wedding on the Ribblesdale Ward at Royal Preston Hospital in October 16, as the happy couple, Emily and Jamie Cross, tied the knot following Emily's terminal cancer diagnosis.

Emily, 43, originally from Shropshire, and Jamie, 44, from Liverpool, have been together for over five years and live together in Preston with baby Mikey, and daughters Eirwen and Sofia, and had recently bought a new house prior to her diagnosis.

Sadly, Emily, a nurse who has trained at Lancashire Teaching Hospitals, has since spent more time in hospital than in their new home. Back in May, she had surgery to remove a cyst, and subsequent biopsies suggested she was cancer-free. She underwent preventative chemotherapy, but after the third round, she returned to the Emergency Department, and tests showed she had a rare type of cancer, mucinous ovarian adenocarcinoma with peritoneal carcinomatosis.

Jamie proposed and the pair were married on the Ribblesdale Ward, after staff decorated Emily's room. They then went down to the chapel, where lead chaplain Martin McDonald blessed the rings.

The story went around the country, appearing on the BBC, as well as in the Liverpool Echo, Manchester Evening News, Wales Online, Shropshire Star, Nottingham Post and our local media.

I'd like to thank our colleagues for making this such a memorable day for this special couple.

- **Theatre Manager Eileen takes well-deserved retirement after 50 years in the NHS**

Eileen Burbridge, who was Theatre Manager at Royal Preston Hospital, is enjoying a well-earned retirement after 50 years in the NHS. Eileen reached her milestone in September before calling it a day last month.

Back in January, Eileen's fellow Theatre Manager Ros Aspinall also celebrated 50 years with the NHS, although Ros admitted she has no plans to finish just yet. The pair spoke about their combined century in the service on the Sharon Hartley show on BBC Radio Lancashire, in an emotional interview.

Eileen started out as a cadet, training at the old Preston Royal Infirmary, Sharoe Green Hospital and Whittingham Hospital on September 2 1974, and then worked in the prescription pricing bureau in the Lostock Hall Medical Centre, before going to Wythenshawe for her State-Enrolled Nurse training.

She then did the first 52-week conversion course in Britain in 1986, converted from SEN to Registered General Nurse, and worked as a staff nurse on a gynae ward, before moving back to Preston in 1990, where she was involved with the commission of the vascular theatres here.

Best wishes to Eileen on her retirement!

- **Midwife wins prestigious award for bereavement care**

Claire Braithwaite was a thoroughly deserving winner of an award from the Royal College of Midwives (RCM) for the standard of personalised care she provides to bereaved families after a pregnancy loss.

Claire, Lead Bereavement Midwife at the Trust, was described as “an angel in human form”, as she won the Outstanding Contribution to Midwifery Services: Pregnancy Loss and Bereavement Care category at the RCM Awards 2024 at The Brewery in London.

The award recognises excellence in bereavement care provision by maternity staff for women and their families when a baby dies, and Claire felt it demonstrates that as an organisation we are getting bereavement care right for families. This approach is appreciated, as mothers, fathers and grandparents have told us in their feedback. Indeed, one family, Hannah and Konrad Sapigorski, spoke to ITV Granada during Baby Loss Awareness Week about the support they received at the Trust following the birth of triplets in February.

Just 22 weeks into the pregnancy, Hannah went into labour, and Asia, Frankie and Kaja were born - each weighing under 500 grams. The couple were told the babies had less than a 6% chance of survival, and a few days after they were born, Frankie passed away. The couple tried to navigate their grief and plan Frankie’s funeral, while their baby girls were still desperately sick in hospital. Now nine-months-old, Asia and Kaja are doing well and were finally able to come home in September.

Hannah and Konrad are grateful for their little miracles, but each day is a sad reminder that there should be three babies at home. They want all parents who lose a baby to reach out for support, and support from Claire and the team at Royal Preston Hospital helped them grieve and also cope emotionally.

- **Broadoaks Matron receives prestigious Queen’s Nurse title**

Congratulations to Victoria Atkinson, Matron for Community and Specialist Services for Children and Young People at Lancashire Teaching Hospitals, who has been awarded the prestigious title of Queen’s Nurse by the Queens Nursing Institute (QNI).

The award is an historic title given to nurses who deliver and lead outstanding care and is open to registered nurses with more than five years’ experience working in the community.

Victoria, who is the only nurse from the Trust to be awarded the title this year, grew up wanting to be a nurse and was inspired to work with children within the community setting by her niece’s experiences. She qualified in 2007, joining the Trust in 2020, and is currently based at Broadoaks Child Development Centre (CDC) in Leyland.

- **Global first operation celebrates key milestone**

A global-first operation, performed for the last five years exclusively at the Trust by three consultant colorectal surgeons, has celebrated a key milestone. Tarek Hany, Alka Jadav and Arnab Bhowmick have performed the 100th case of extra-peritoneal colorectal surgery (EXPERTS) – a novel operation “designed and performed with a view of the future in mind”.

To demonstrate the procedure, the surgeons use a combination of 3D animation and Virtual Reality simulation developed at the Trust. The unique method avoids puncturing the peritoneum, going underneath the bowel, directly to the area of importance. This helps avoid awkward patient position on the operating table and avoids injuries to other organs.

The procedure is performed with the patient in the supine position, face up, as opposed to the head down position where the feet are raised higher than the head, and there is growing evidence that it is more effective than standard keyhole surgery.

There is low risk of compartment syndrome, there is also reduced pressure within the lungs and eyes and reduced shoulder injury as is potentially the case with standard keyhole surgery in which patients have to be tilted in the head down position.

Extra-peritoneal colorectal surgery has been presented to learned national and international societies as a world first and has been widely published in scientific literature.

1. RECOMMENDATIONS

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

8. BOARD ASSURANCE FRAMEWORK

Decision Item | S Regan | 13:20

REFERENCES

Only PDFs are attached

08.0 - Revised Board Assurance Framework - Dec 2024 - Final.pdf

Board of Directors Report

Board Assurance Framework (BAF) Risk Report

Report to:	Board of Directors	**Date:**	5th December 2024
Report of:	Associate Director of Risk and Assurance	**Prepared by:**	K Clay
Part I	✓	**Part II**	

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

Executive Summary:

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

This paper provides the Board of Directors with an update on the strategic risks that may compromise the achievement of the Trust's high level strategic objectives which have been discussed through Committees of the Board since the Board meeting in October 2024.

The paper also proposes a change in approach in respect of the Board Assurance Framework and a draft version of the proposed new Board Assurance Framework is attached to consider adoption by the Board.

Linked to the proposed change in approach, there is a requirement to review the Trust's Risk Appetite and Tolerance, and the paper includes a proposal for the Board to consider.

Strategic Risks

A copy of the Trust's current BAF can be found in Appendix 1, whilst Appendix 2 provides the Strategic Risks with full details of the controls, assurances, any gaps and actions that are being undertaken to mitigate the strategic risks. Due to scheduling of committees, the strategic risks that are detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

The current BAF in Appendix 1 identifies the strategic risks that may threaten the delivery of the strategic aims and ambitions of the Trust.

There has been no change in score for:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.

Operational High Risks for Escalation/De-escalation

There are three operational high risks that continue to be escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact of exit block on patient safety, which has been escalated to Board since December 2020 due to the occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to the recovery of cancer, and non-cancer backlogs.
- Risk ID 1157 (scoring 20), Increased cases of clostridioides difficile (C.*difficile*) Infection, which has been escalated to Board since April 2024.

Review of the Board Assurance Framework

As noted in the previous Board of Directors meeting, a review of the Board Assurance Framework has been undertaken following a request from the Chair and Chief Executive. The review was also considered timely to align with the development timeline for the new Trust strategy. Although the approval of the new Trust strategy has been delayed, this does not impact the proposed change in approach to the Board Assurance Framework.

The Trust currently uses a strategic risk approach, which has been in place since 2020 and aligns risks to the long-term strategic aims and ambitions of the organisation. However, following the review, a change in approach is proposed a model that identifies Principal risks to the delivery of the Corporate Objectives.

In developing the proposed principal risks, the Associate Director of Risk and Assurance & Executive Team have:

- Reviewed the corporate objectives agreed by the Board of Directors in June 2024.
- Reviewed assurances available across the corporate objectives and programmes of work to determine where there are potential risks to the delivery of the corporate objectives.

Meetings were undertaken with Non-Executive Directors as part of developing the approach and the proposed principal risks and an abridged version of the Board Assurance Framework were presented at a Board Workshop on 21st November 2024 to familiarise colleagues and explain the planned approach in more detail, in advance of the Board of Directors meeting in December 2024.

A full copy of the proposed principal risks is included in the proposed new Board Assurance Framework, which is included at Appendix 3.

Risk Appetite & Tolerance

In proposing a change in approach to a Principal Risk model, and to align to the Trust's new strategy approach, the Trust's Risk Appetite and Tolerances will need to be reviewed to ensure alignment with the Trust's strategic priorities outlined in the Corporate Objectives, and the risk landscape.

Proposed revised Risk Appetite and Tolerances are included in Appendix 5 and a proposed revised Risk Appetite Statement is included in section 6.4 of the report.

Transition Arrangements

Should the Board of Directors adopt the new approach, it is proposed the current strategic risks will be controlled to support the transition to the new approach. Whilst the current risk scores are not in tolerable range, the principal risks have been identified in consideration of the Corporate Objectives. This ensures that the areas of focus contained within the Strategic Risks have been appropriately captured as part of the new approach. Open actions will continue to be monitored and reported on until completion.

Transition arrangements for the currently escalated Operational High Risks of Concern are outlined in section 7.5 of the report.

Risk Management Policy

The Risk Management Policy is under review and will incorporate the proposed changes following adoption by the Board of Directors. Given the timings of Audit Committee and the next Board of Directors meeting, and to allow for wider consultation on the policy and changes, it is proposed to submit the revised policy for Chair's approval in advance of the next Audit Committee and Board of Directors meeting. The policy will then be shared with Audit Committee for validation and the Board of Directors in February 2025.

It is recommended that Board of Directors:

i. Note and approve the updates to the current version of the BAF.
ii. Approve that the current Strategic Risks be Controlled, with the transitional arrangements to be adopted until actions are complete.
iii. Formally adopt the new Principal Risk Approach to the Board Assurance Framework and the proposed Board Assurance Framework in Appendix 3.
iv. Formally adopt the revised Risk Appetite Statement and tolerances outlined in the paper.
v. Approve the proposals related to the three Operational High Risks of Concern currently escalated to Board.
vi. Endorse the approach to the Risk Management Policy being subject to Chairs approval in advance of the next Audit Committee and Board of Directors' meetings.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks
Appendix 3 – Proposed new Board Assurance Framework
Appendix 4 - Risk Appetite scale and Risk Matrix
Appendix 5 - Current and proposed risk appetite and tolerances.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Committees of the Board in line with cycles of business

1. Background

1.1 The Well Led Framework by NHS England and the Care Quality Commission (CQC) requires Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extends to include 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 strategic risks that may compromise the achievement of the Trust's high level strategic objectives which have been discussed through Committees of the Board since the Board meeting in October 2024.

1.3 The paper also proposes a change in approach in respect of the Board Assurance Framework and a draft version of the proposed new Board Assurance Framework is attached to consider adoption by the Board.

1.4 Linked to the proposed change in approach, there is a requirement to review the Trust's Risk Appetite and Tolerance, and the paper includes a proposal for the Board to consider approving.

2. Current Board Assurance Framework

2.1 The BAF in Appendix 1 identifies the current strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust and are those that have been reviewed by Committees of the Board since the last Board meeting.

2.2 Strategic Risk Register

2.2.1 Since the last update to Board, there has been no change in score for:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.

2.2.2 Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template in Appendix 2.

2.2.3 It should be noted due to scheduling of committees, the strategic risks detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

2.2.4 At Finance and Performance Committee, the committee acknowledged the updates to the Fit for the Future risk and actions. It was agreed to discuss outside of the meeting to consider if any refresh is needed of the Fit for the Future risk, which may be addressed upon agreement of the Trust strategy and through the proposed transition to the new Board Assurance Framework.

2.3 Operational Risk Register

2.3.1 There are three operational high risks that continue to be escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to recovery of cancer, and non-cancer backlogs.
- Risk ID 1157 (scoring 20), Increased cases of clostridioides difficile (C.difficile) Infection, which has been escalated to Board since April 2024.

2.3.2 Further details on the operational high risks escalated to Board can be found in the BAF in Appendix 1.

3. Review of the Board Assurance Framework

3.1 Context

3.1.1 As noted in the previous Board of Directors meeting, a review of the Board Assurance Framework has been undertaken following a request from the Chair and Chief Executive. The review was also considered timely to align with the development timeline for the new Trust strategy. Although the approval of the new Trust strategy has been delayed, this does not impact the proposed change in approach to the Board Assurance Framework.

3.1.2 The Trust currently uses a strategic risk approach, which has been in place since 2020 and aligns risks to the long-term strategic aims and ambitions of the organisation. Whilst this approach has served the Trust well, the broad nature of these risks has made it challenging to measure or demonstrate tangible progress in some areas. Feedback from the wider Board indicated a review of the approach was therefore required.

3.1.3 The review was undertaken by the Associate Director of Risk and Assurance who compared the Trust's approach to guidance available from NHS Providers, the BAFs at other NHS organisations, and the Government's Orange Book guidance on the concept of risk management.

3.1.4 The review also included a survey of the Board of Directors and considered additional feedback gathered during Committee meetings of the Board, Board of Directors' meetings, and separately through discussions with Executive and Non-Executive Directors.

3.1.5 The outcome of the review was presented as part of the Board Risk Management Training day on 25th July 2024 with a recommendation to change from a strategic risk approach to a principal risk approach. This recommendation was positively received by Board members who were present with the view that this has the potential to improve risk prioritisation linked to the delivery of the annually developed corporate objectives, which are designed to support delivery of the overall strategic objectives of the organisation.

3.1.6 Following the Board training day, the Associate Director of Risk and Assurance has sought to develop a revised Board Assurance Framework with a model that identifies principal risks to the delivery of the Corporate Objectives.

4. Key Changes in Approach

4.1 Strategic Objectives

4.1.1 The new Trust strategy is in draft and indicates a change in approach from the strategic aims and ambitions previously used in the Trust to Strategic Objectives, identified as the '5 Ps':

- **Patients** – deliver excellent care
- **Performance –** deliver timely, effective care
- **People –** be a great place to work
- **Productivity –** deliver value for money
- **Partnership –** be fit for the future

4.1.2 The Corporate Objectives were approved by the Board of Directors in June 2024 and were linked to the 5P's.

4.2 Risk Identification and Categorisation

4.2.1 The principal risk model identifies risks based on their potential impact on the delivery of corporate objectives, rather than risks to the delivery of strategic aims/ambitions. This provides the ability to be agile to emerging risks and prioritisation in line with best practice guidance.

4.2.2 There will still be the opportunity to escalate operational risks to the Board of Directors via Committees of the Board where there may not be a risk to delivery of a corporate objective but where there is an identified need for escalation and oversight.

4.3 Enhanced Risk Reporting and Monitoring

4.3.1 The proposed new BAF will include enhanced reporting to provide more detailed analysis of each principal risk, and detailed mitigation plans, allowing systematic monitoring in line with best practice guidance.

4.3.2 Upon formal adoption by the Board, the principal risks will be reported to the identified Committee of the Board each month in line with current practice, and presented at the Board of Directors as part of the Board Assurance Framework at each meeting.

5. Development of proposed principal risks

5.1 In developing the proposed principal risks, the Associate Director of Risk and Assurance & Executive Team have:

- Reviewed the corporate objectives agreed by the Board of Directors in June 2024.
- Reviewed assurances available across the corporate objectives and programmes of work to determine where there are potential risks to the delivery of the corporate objectives.

5.2 Meetings have been undertaken with Non-Executive Directors as part of developing the approach.

5.3 The proposed principal risks and an abridged version of the Board Assurance Framework were presented at a Board Workshop on 21st November 2024 to familiarise colleagues and explain the planned approach in more detail, in advance of the Board of Directors meeting in December 2024.

5.4 A full copy of the proposed principal risks is included in the proposed new Board Assurance Framework, which is included at Appendix 3.

6. Risk Appetite and Tolerance

6.1 In proposing a change in approach to a Principal Risk model, and to align to the Trust's new strategy approach, the Trust's Risk Appetite and Tolerances will need to be reviewed to ensure alignment with the Trust's strategic priorities outlined in the Corporate Objectives, and the risk landscape.

6.2 As there are synergies with some of the previous Strategic Aims and Ambitions, an amended Risk Appetite Statement, Risk Appetite scores and Risk Tolerance levels has been drafted, which:

- Removes the previous Strategic Aims and Ambitions of driving health innovation through world class Education, Training & Research
- Removes the strategic aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria
- Introduces the 'Performance' objective, proposed to align to the same appetite and tolerances as those for 'Patients', given the strong correlation between performance and patient outcomes.

6.3 This was also discussed at the Board Workshop on 21st November 2024. A copy of the Risk Appetite scale and Risk Matrix is included at Appendix 4 and a copy of the current and proposed risk appetite, and tolerances is included at Appendix 5.

6.4 A proposed risk appetite statement is included below and it is recommended that the Board of Directors adopt this:

> Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **deliver excellent care for Patients,** our **Performance** needs to support the delivery of **timely, effective care** and we recognise that, in pursuit of these overriding objectives, we may need to take other types of risk which impact on different organisational objectives. Overall, our risk appetite in relation to **Patients** and **Performance** is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.
>
> We have an open appetite for those risks which we need to take in pursuit of our commitment to being **a Great Place to Work for our People.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce with the right skills and knowledge, this tolerance does not extend to risks which compromise the safety of our **People**, or undermine our Trust values.
>
> We also have an open appetite for risk in relation to our strategic objective in relation to **Productivity, to Deliver Value for Money**. However, we are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the Trust's use of public funds.

We seek to be **Fit for the Future** through our commitment to working in **Partnership** with organisations in the local health and social care system to make current services sustainable and develop new ones. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

7. Transition Arrangements

7.1 Should the Board of Directors adopt the new approach, it is proposed the current strategic risks will be controlled to support the transition to the new approach. This includes the:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.

7.2 Whilst the current risk scores are not in tolerable range, the principal risks have been identified in consideration of the Corporate Objectives. This ensures that the areas of focus contained within the Strategic Risks have been appropriately captured as part of the new approach.

7.3 As there are open actions included in the current strategic risks, it is important to ensure these are appropriately monitored to a conclusion. These actions will continue to be reported as a separate action log to Committees of the Board and the Board of Directors meeting, except in the case where these are already included as part of an action in response to a principal risk in the new Board Assurance Framework.

7.4 Initial reporting to Committees of the Board for their relevant aligned Principal Risks is planned to commence from December 2024.

7.5 In terms of the Operational High Risks of concern that are currently escalated to Board, it is recommended that the Board accept the proposals outlined below in recognition that all three escalated risks are now captured within the Principal Risks:

Escalated Operational High Risks of Concern	Proposal
Risk ID 25 (scoring 20), Impact on exit block on patient safety	De-escalate the operational High Risk of Concern on the basis that the Board will retain oversight of this risk through: Principal Risk 1 – Patient experience within the urgent and emergency care pathway (Scoring 12). Principal Risk 5 - Timely access to urgent and emergency care (Scoring 20).
Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to recovery of cancer, and non-cancer backlogs.	Formally adopt this reviewed risk as: Principal Risk 4 - Timely access to planned and cancer care
Risk ID 1157 (scoring 20), Increased cases of clostridioides difficile (C.difficile) Infection, which has been escalated to Board since April 2024.	Formally adopt this reviewed risk as: Principal Risk 2 - Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection

8. Risk Management Policy

8.1 The Risk Management Policy is under review and will incorporate the proposed changes following adoption by the Board of Directors. Given the timings of Audit Committee and the next Board of Directors meeting, and to allow for wider consultation on the policy and changes, it is proposed to submit the revised policy for Chair's approval in advance of the next Audit Committee and Board of Directors meeting. The policy will then be shared with Audit Committee for validation and the Board of Directors in February 2025.

9. Financial implications

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

10. Legal implications

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

11. Risks

11.1 The paper identifies Strategic 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.

12. Impact on stakeholders

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

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

13. Recommendations

13.1 It is recommended that Board of Directors:

i. Note and approve the updates to the current version of the BAF.
ii. Approve that the current Strategic Risks be Controlled, with the transitional arrangements to be adopted until actions are complete.
iii. Formally adopt the new Principal Risk Approach to the Board Assurance Framework and the proposed Board Assurance Framework in Appendix 3.
iv. Formally adopt the revised Risk Appetite Statement and tolerances outlined in the paper.
v. Approve the proposals related to the three Operational High Risks of Concern currently escalated to Board.
vi. Endorse the approach to the Risk Management Policy being subject to Chairs approval in advance of the next Audit Committee and Board of Directors' meetings.

Risk Title: Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care

Risk ID: 855
Risk owner: Chief Nursing Officer
Date last reviewed: 17th November 2024

Risk
There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to:
a) Availability of staff
b) High Occupancy levels
c) Fluctuating ability to consistently meet the constitutional and specialty standards
d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services.
e) Health inequalities across the system

This may, result in adverse patient outcomes and experiences.

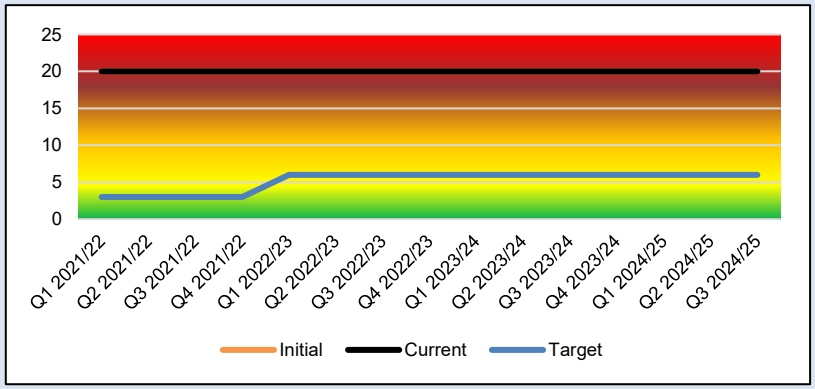
Risk Appetite:
Cautious to Risk – Willing to accept some low risk, whilst maintaining an overall preference of safe delivery options.

Risk Tolerance
1-6

Rationale for Current Score

- There is currently a reliance on temporary workforce due to sickness levels in excess of 4% and greater than 5% vacancy levels resulting in variation in care delivery.
- The requirement to deliver a Cost Improvement Programme of 7% of addressable spend and overall Financial Recovery Plan in excess of 8.5%.
- Continued deterioration in the backlog maintenance position and the impact on both buildings and equipment.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate standards.
- Occupancy levels are in excess of 95% leading to extended length of stay in the ED and additional patients boarding on inpatient wards.
- Patients are routinely waiting longer than some national standards for treatments and in the Emergency Department.
- Adult inpatient experience feedback is identifying room for improvement.
- The ability to live within the resources available is dependent upon scalable system wide transformation. The foundations for this work remain formative.
- C.*Difficile* rates exceed expected rates and allocated trajectory (managed through Risk ID 1157 – Increased risk score now at 20 associated with C. *difficile* Infection)
- Recognised health inequalities in the communities we serve.
- The CQC rating for the organisation has remained at 'Requires Improvement'.
- There are some specialty services that are considered fragile and this presents a risk to consistent delivery.

Risk Rating Tracker * (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 4x5 = 20 Target: 1-6



*Initial score also 20 throughout but covered by current score line on above graph

Future Risks

- Risk of New Hospital Programme not progressing.
- Risk that the backlog maintenance of the estate may reach a point where closures of departments is required due to unsatisfactory estate conditions.
- Failure to improve existing operational flow arrangements.
- Failure to address system health inequalities.
- Failure to progress with transformation at scale to live within resources available to us.
- Risk of further financial constraints presenting increased risk to delivery of safe and effective care.

Future Opportunities

- ICS networks and collaboration leading to reconfiguration of fragile services.
- New Hospital Programme delivery.
- Reduction in agency use, vacancy and sickness levels will present an increase likelihood of improved outcomes and experiences for patients and staff.
- Closer working relationship across the health and care system in partnership with public health presents opportunities to level up access to services and design out system inequalities.
- Mobilisation of transformation at scale across the system.

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies and plans in place ○ Always Safety First ○ Clinical Strategy ○ STAR Quality Assurance Framework ○ Patient Experience and Involvement Strategy ○ Risk Management Policy ○ Our Big Plan ○ Continuous Improvement Strategy ○ Equality, Diversity and Inclusion Strategy ○ Workforce and OD Strategy ○ Education, Training and Research Strategy ○ Financial Strategy ○ Health and Wellbeing Strategy ○ Communication Strategy ○ Targeted recruitment & plans and temporary staffing arrangements (inc international and healthcare support workers) ○ Safety and Quality Policies and Procedures ○ Workforce Policies and Procedures ○ Health & Safety Plan ○ Operational Plan ○ Restoration and Recovery Plan ○ Safe staffing reviews ○ Safeguarding Board • Accountability Framework • Freedom to Speak Up, Guardian of Safe Working and Person in Position of Trust (PIPOT) arrangements • Safety Forums • GIRFT programme of work. • Capital planning process • EQIA policy and procedures • Transformation programme • Integration of services and pathways and effective system-based working • Confirmation received of progression to the next stage of the NHP in May 2023 • Capital investment case created expand the MAU and SAU. • Health Inequalities delivery plan - Core20PLUS5 adults and children. • Medical device and replacement programme and process in place with increased oversight through Finance & Performance Committee • Planned programme of work commenced focused on fragile services across the ICS.	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups ***(Ref CDEC 020)***. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection ***(Ref CDEC 019).*** • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 019)*** • The current environment within surgical assessment units does not meet demand. ***(CDEC 014b)*** • The implementation of the national cleaning standards is not yet complete. ***(CDEC 018)*** (02/24 - 25% compliant for domestic standards, 100% compliant for nursing standards.) • The capital required to address backlog maintenance is not sufficient. ***(CDEC 019)*** • The environment and facilities within the children's ward require improvement. (***CDEC 021)*** • The increasing finance and operational pressures present potential risk to patient and staff safety and experience. ***(CDEC 023)*** • The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient. ***(CDEC 024, CDEC 028 and CDEC 029)***	**Internal** • STAR Assurance Framework in place with mandated fundamental standards to achieve green detailed and reported through Safety & Quality Committee. • Always Safety First Learning and Improvement Group • PSIRF Oversight group • Divisional Governance Structures and arrangements • Divisional Improvement Forums • Safety and Quality Committee • Workforce Committee • Finance and Performance Committee • Education, Training and Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system • CNST internal assurance reporting • Nurse, Midwifery and AHP safe staffing review annual review and recommendations • Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing • Equality Quality Impact Assessment (EQIA) procedure and reporting in place. • Transformation programme Board • Strengthened IPC BAF • Director of Strategy and Planning reports updates on clinical reconfiguration programmes to Finance and Performance Committee. • Bi annual safe nurse staffing assessment completed with inclusion of covering safe staffing recommendations for 2023 Birthrate plus assessment. **External** • National Surveys • Clinical Negligence Schemes for Trust • Validation of year 5 CNST 10 maternity safety actions • External regulators and benchmarking	[None detailed]

• Acute Medical Unit opened in October 2024 to provide expansion of MAU. • Partnership Agreement in place with LSCFT to transform physical health community services to improve length of stay in ED and as inpatients.		• Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 014 A	Completion of planned expansion of MAU.	Chief Operating Officer	30 November 2024	1 October 2024	Completed	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 014 B	Completion of planned expansion of SAU	Chief Operating Officer	31 March 2025		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 016	Determine mechanism to fund safe staffing recommendations for 2023 Birthrate plus assessment.	Chief Financial Officer	30 April 2024	6 April 2024	Completed	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 017	Bi annual safe nurse staffing assessment to be undertaken given the time elapsed since previous assessment and changes in operating environment.	Chief Nursing Officer	30 April 2024	6 April 2024	Completed	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 018	The national cleaning standards implementation requires delivery – Priority 1.	Chief Financial Officer	~~31 August 2024~~ Unable to determine delivery date		Ongoing	Control	• The implementation of the national cleaning standards is not yet complete. 25% compliant for domestic standards, 100% compliant for nursing standards.
CDEC 019	The capital planning group will continue to assess the risks relating to backlog maintenance and determine the priorities from within the capital funding envelope provided.	Chief Financial Officer	ongoing		Ongoing	Control	• The capital required to address backlog maintenance is not sufficient. • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
CDEC 020	To develop a plan in conjunction with the Director of Public Health, that aligns with the Health and Wellbeing Board's Health Inequalities Plan.	Chief Nursing Officer	~~31 October 2024~~ 30 November 2024		Ongoing	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.
CDEC 021	To develop a plan to improve environment within the children's ward.	Chief Nursing Officer	30 April 2025		Ongoing	Control	• The environment and facilities within the children's ward require improvement.

CDEC 022	To review STAR and mandated fundamental standard delivery to achieve green and disaggregate inpatient outcomes from outpatients to strengthen assurance.	Chief Nursing Officer	31 August 2024	31 August 2024	Completed	Assurances	• The approach to quality assurance within inpatient areas and specific focus on fundamentals requires strengthening.
CDEC 023	Further review of the Equality Quality Impact Assessment process.	Chief Nursing Officer	30 June 2024	30 June 2024	Completed	Assurances	• The increasing finance and operational pressures present potential risks to patient and staff safety and experience.
CDEC 024	Undertake analysis of demand and capacity across the UEC pathway to determine capacity required.	Chief Operating Officer	30 November 2024	30 October 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 025	Agree in partnership with LSCFT the approach to transforming physical health community services to improve length of stay in ED and as inpatients.	Chief Nursing Officer	30 September 2024	30 September 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 026	Develop a central Lancashire PLACE Urgent and Emergency care plan.	Chief Operating Officer	31 July 2024	11 September 24	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 027	Revisit the LTHTR Urgent and Emergency Care plan to reflect system and organisational priorities.	Chief Operating Officer	31 July 2024	31 July 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 028	Agree funding approach to Finney House intermediate care service to secure immediate to medium term plan.	Chief Nursing Officer	~~30 September 2024~~ 31 January 2025		Ongoing	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 029	Agree the winter plan to mitigate against the increased risk associated with winter.	Chief Operating Officer	31 October 2024	31 October 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.

Summary of review – October and November 2024

- Action CDEC 014 split into 2 actions to account for opening of new areas at different times.
- Action CDEC 014A – Disaggregated action to reflect delivery of the new Acute Medical Unit (AMU) which opened in October 24. This leads to update of the gap in control remaining around surgical assessment unit and the new control measure identified with AMU opening.
- Action CDEC 014B – created new action to reflect the new build of the Surgical Assessment Unit, scheduled to be opened by the end of quarter 4.
- Action CDEC 020 - The delivery date for the health inequalities plan has been extended due to stakeholder feedback and is expected to be complete by 30 November 2024 due to competing priorities.
- Action CDEC 024 – Action completed, with Demand and Capacity analysis complete and being used to inform next steps on capacity plans
- Action CDEC 025 – marked as completed, which in turn removes a gap in control and identifies a new control in place regarding partnership agreement with LSCFT to transform community services to improve length of stay in ED or as inpatient.
- Action CDEC 028 – Extended due to an inability to close the gap of funding required to fully fund Finney House. Placed on the agenda for the Improvement and Assurance group IAG in October 2024 and raised as part of the System Improvement Board.
- Action CDEC 029 – new action identified in September 2024 and completed in October 2024. Winter plan is in place, which was presented to Safety and Quality committee in October 2024.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money

Risk ID: 857
Risk owner: Chief Finance Officer
Date last reviewed: 18th November 2024

Risk

There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

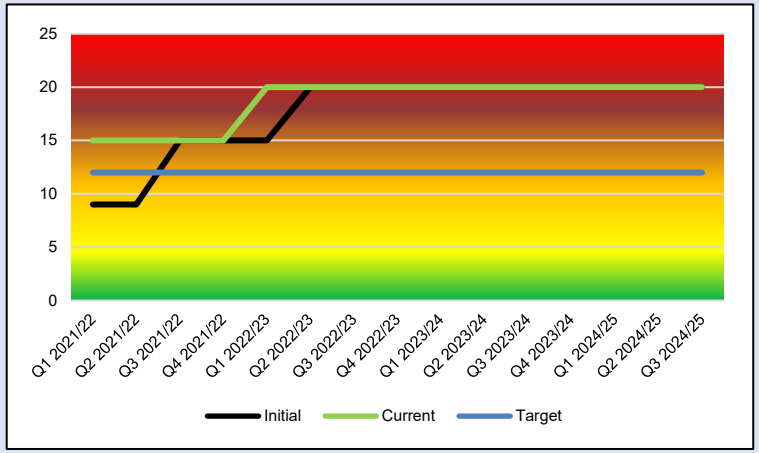
8-12

Rationale for Current Score

- **Undertakings** The Trust is in segment three for the NHS Oversight Framework (NOF). Undertakings applied by NHSE to the Trust include the need for the Trust to agree its financial plans with the Integrated Care Board, a requirement to deliver that plan and a supporting need to deliver the associated cost improvement plan. The Trust must close a gap of £58m in 2024-25. The Trust has enforcement undertakings relating to its financial position. This may result in a move to 'NOF' four. As at month 6 the Trust is reporting a forecast year end variance to financial plan of £30m i.e. a deficit of £52.9m driven principally by under delivery of our savings programme. The deterioration of our forecast has resulted in escalated scrutiny from NHSE and the I&I improvement lead.
- **Excess urgent care demand** – Excess flow related demand on the non-elective pathways continues to place pressure on the UEC pathway. Despite additional capacity, the Trust's performance standards are not being met.
- **Industrial relations** – Continuing industrial tension is giving rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trust's ability to mitigate the impact of these tensions is limited, without some further consequence.
- **Financial recovery (Trust)** – The Trust is unable to deliver a balanced plan for 2024-25 and will aim to rebalance its finances over a three-year period. The Trust has set a challenging financial improvement target for future years, and it needs to ensure that the associated change is managed through an effective equality and quality impact assessment process.
- **Financial Recovery (system)** – In outlining their financial plans all NHS organisations in Lancashire and South Cumbria will be challenged to deliver their financial trajectories. To do so will likely lead to changes in the commissioning and provision of services. Some of these changes will inevitably impact on arrangements with partners which may impact further on delivering value for money. In addition, an external Improvement Director has been assigned to the ICS to support speedier financial recovery.
- **Productivity** – Despite significant transformation programmes, Trust productivity when compared to 2019-20 has decreased. Input costs have essentially risen faster than the measured outputs. This has directly impacted upon value for money.
- **Dependencies** – Whilst there are many improvements to be driven internally, to further improve value for money there are many dependencies on partners, e.g. to develop a clear out of hospital strategy, to help tackle not-meeting criteria to reside, to support the reorganisation of services or to fund the alternatives to hospitalised care.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x5 = 20 Target: 8-12



The score of 20 reflects the underlying financial position of the Trust.

	Future and Escalating Risks • **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust, along with potential future risk of failing to deliver the Trust's challenging FRP. • **Placed based leadership** – The place-based roles are continuing to form and are considered to be pivotal in the optimisation of the health and care 'eco-system'. There is a risk that the evolution of these arrangements do not sufficiently impact on the optimisation processes and that leadership arrangements between sub place, place and system are confusing with unclear accountability. • **Rising demand** – Failure to develop a credible and meaningful urgent and emergency care strategy at system and place to respond to a growing population with increased complexity/comorbidity will result in residents accessing inappropriate services which could impact detrimentally on value for money for public services as a whole. • **Planned care -** The failure to reorganise planned care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money. • **Cost control –** The scale of variance from financial plan has driven significant tightening of internal controls for pay and non-pay spend as part of the I&I process, but as at month 7 they are not delivering significant savings. • **Commissioning decisions –** In light of the wider system financial challenges it is likely that the ICB will need to disinvest in services which are likely to exacerbate the financial and operational challenges if unmitigated. • **National financial framework –** The national framework has now been issued this clarifies that overspending systems will have capital allocations curtailed and will result in top sliced allocations in future periods. • **Financial Recovery** - Month 7 financial position £8m away from forecast submitted at month 4 driven principally by under-delivery of the FRP and I&I.	**Future Opportunities** • The requirement to drive future opportunities into the "here and now" is essential and additional support is being secured with NHSE. • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There is opportunity to participate in the national support offer for NHS IMPACT, which will focus on increasing productivity in priority areas • There remains an opportunity to increase margins through non-NHS activities. • There remains opportunity through the ICS and the place-based arrangements to reduce the unnecessary duplication of NHS services. • There is an opportunity to work with the Provider Collaboration Board to identify and pursue collaboration opportunities at scale. • There remains an opportunity to commission more effective services to mitigate hospital attendances. • There remains a partnership opportunity at system and place to better manage patient pathways and reduce inappropriate demand and unnecessary cost escalation. • There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes. • To meet increasing demand and complexity the ICB will need to determine what commissioned services will be afforded for its population and whether some services will need wider reconfiguration to support sustainability. • Better understand why relative productivity has decreased and seek to mitigate where possible. • There is opportunity to commission end to end pathways to maximise out of hospital care, closer to home.

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurance**
• Workstream related strategies in place ○ Workforce and OD Strategy, ○ Continuous Improvement Strategy ○ Clinical Strategy ○ Financial Strategy ○ IM&T Strategy, ○ Estates Strategy, ○ Annual Business Plan Planning framework established to track delivery of schemes. ○ Always safety first	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action)) • Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision	**Internal** • Specialty Performance meetings • Divisional Improvement Forums • Performance Review Group • Outpatient Improvement Group • Integrated Performance reporting at Finance and Performance Committee and Board • Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system • Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the NHS Oversight Framework (NOF)). • Use of Resources assessments now reported through Finance & Performance Committee.	• Update on the developing Clinical Strategy from the ICS. • Month 7 financial position is £8m away from forecast. Further assurances needed on financial risk assessment of FRP scheme delivery.

○ Urgent and Emergency Care Board ○ ICS Transforming Community Services Programme • Scheme of delegation/Standing Financial Instruction • Refreshed Performance & Accountability Framework • Long term case for change the New Hospitals Programme • Contract management and activity under regular monitoring • National Planning Framework and Capital now given to ICS areas. • A system wide vacancy and control panel introduced providing additional oversight of the roles that are being recruited to across the system, particularly but not exclusively in non-clinical areas, consultancy, leases and contracts. • A system wide non pay control group has been established with the aim of prohibiting discretionary spend and improving value for money. • Revised benefits realisation approach to aid programme management and continuous improvement • Refreshed planning cycle for 2025/26.	taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy) • The savings programme alongside additional control measures is currently failing to deliver the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 24/25 ***(DVFM 039)***.	• Regular embedded cycle of sharing information relating to the wider programme of change in place • Report on elective productivity and plans for improvement completed to better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement. • A monthly update is provided to the Finance and Performance Committee on the Financial Recovery Programme • Temporary Workforce Controls have been reviewed by internal audit and gained substantial assurance. • A Single Improvement Board has been established, chaired by the CEO which will report into Finance and Performance Committee • Updates on the drivers of financial and operational performance shared with Finance & Performance Committee • Single Improvement Plan (SIP) Board **External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB including a new system improvement board, chaired by the NHS England regional team. • The contract monitoring report is shared with FPC to provide stronger assurances on the underlying trading position and associated activity now reintroduced. • The I&I improvement lead has made a number of best practice improvement recommendations around temporary pay management that the trust are currently implementing	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	Develop Financial Sustainability Plan as part of the single improvement plan. The Trust's Turnaround Director is focussing on maturing the recovery plan for 2024-25. This should be completed by the end of June.	Chief Financial Officer and Director of Strategy and Planning	30.06.24	30.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance.
DVFM 033	Review performance and accountability framework **Note:** NHS England have updated their oversight framework. This will delay the delivery of the revised PAF.	Director of Improvement, Research and Innovation	30.09.24	30.09.24	Complete	Assurance	Inability to demonstrate delivery of key financial and operational metrics
DVFM 034	Develop the People and Culture Plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief People Officer	30.06.24	06.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance
DVFM 035	Develop an Operational Performance plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief Operating Officer	30.06.24	06.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance
DVFM 036	To review planning cycle ahead of 2025/2026.	Director of Strategy and Planning	30.09.24	30.09.24	Complete	Control	Delays in planning cycle
DVFM 037	Review approach to benefits realisation for programme management and continuous improvement	Director of Improvement, Research and Innovation	30.08.24	30.08.24	Complete	Control	Embody changes such as EVO into the improvement work to better capture benefits
DVFM 038	Report of the UEC Delivery Board Improvement Programme through the Single Improvement Plan and the Financial Recovery Plan.	Chief Operating Officer	31.07.24	31.07.24	Complete	Assurance	Provide assurance on externalities and impact on internal programme.
DVFM 039	Robust delivery of the financial recovery plan and other financial risks which may arise during the course of 2024/25	Chief Financial Officer and Turnaround Director	31.03.25		At Risk	Control & Assurance	The savings programme alongside additional control measures is currently failing to deliver the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 24/25

Summary of updates to risk – October and November 2024

- Rational for Current Score updated to include updates on the progress against savings plan
- Narrative regarding Cost Control updated within Future and Escalating Risk content
- Narrative regarding NHSE support on Future Opportunities updated.
- Gap in control related to savings programme reworded to a more updated narrative, aligned to Action DVFM 039.
- Single Improvement Plan (SIP) Board as an assurance and a gap in assurance in relation to DVFM039 as the delivery of this action is at risk with the Month 6 financial position £5.5m away from forecast submitted at month 4 driven principally by under-delivery of the FRP and I&I.
- Additional External Assurance documented regarding I&I Improvement Lead best practice recommendations.
- Action DVFM 033 noted as complete. Accountability framework approved at the Board of Directors meeting in October 2024.
- Action DVFM 036 noted as completed as there is a refreshed approach and planning cycle for 2025/26.

Risk Title: Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work

Risk ID: 856
Risk owner: Chief People Officer
Date last reviewed: 16th October 2024

Risk

There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development.

This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

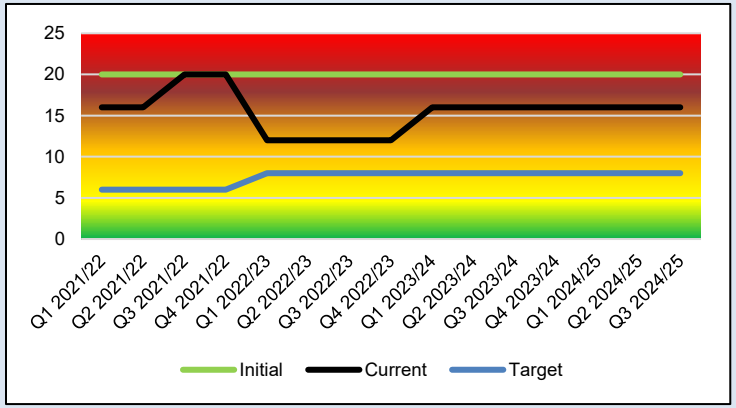
4-8

Rationale for Current Score

- Workforce shortages and some 'hard-to-recruit-to' posts in some specialities and high sickness levels in some key professional groups, creates pressure on existing staff and increases the need for temporary staffing spend.
- Physical environment and colleague facilities (catering) cited as a concern by departments and teams for having an impact on feeling valued, wellbeing and ability to work effectively.
- Leadership ability and capacity impacting on levels of staff satisfaction, cultural transformation and workforce metrics in a number of areas.
- High levels of sickness absence related to mental health issues and musculoskeletal injuries presenting cost and capacity issues.
- Gap between the desired and the current culture indicates improvements are needed.
- The impact of uncertainty and clear direction from One LSC plans is leading to higher levels of turnover, inability to recruit to vacancies, reduced engagement and morale levels in teams potentially affected by the changes, making it difficult to deliver on strategic plans described in Our People Plan.
- Insufficient resource within the Workforce and OD team to deliver change programmes at pace and respond to changing directions from the One LSC programme and ICS -led plans.
- We are seeing an increased appetite for the establishment of an engagement with Limited Liability Partnership (LLPs) by some Consultant groups, this takes sensitive navigation and also a requirement that adequate governance is in place to ensure adequate controls and regulation.
- Trustwide Financial Recovery agenda requires resource and is impacting on colleague morale, making it harder for staff to focus on working practices, culture.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x4 = 16 Target: 4-8



the use of temporary staffing and poor patient care.	**Future Risks** • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of delivery of financial turnaround on staff morale • The lengthy leading time for delivering the New Hospital Programme impacting on ability to utilise available workforce effectively. • Efficiencies anticipated through One LSC are not currently evidence based and pose a risk to the ongoing delivery of corporate services.	**Future Opportunities** • Optimising the ability to develop contract flexibility and reciprocal help across Lancashire & South Cumbria footprint. • Changes to models of care present opportunities to remodel workforce. • Continued opportunity to use the multi professional skills of our workforce in different ways to help tackle specific workforce shortages. • Create a first-class working environment as part of the New Hospitals Programme • Redesign and implementation of more effective and consistent off boarding processes in order to retain a positive perception of leavers with regards to their employment experience. • Central services collaboration may provide opportunities to develop services, efficiencies and resilience to some services once in place and embedded. • Optimisation of "Anchor Institution" status.

Controls • Our People Plan - Workforce and OD strategy related strategies and plans in place ○ Single Improvement Plan ○ Trust Values ○ Workforce Plan ○ Attendance Management Reduction Plan ○ Targeted recruitment & plans (international and healthcare support workers) ○ Workforce policies with EIA embedded ○ Health and Wellbeing strategy ○ Just culture ○ Regular temperature checks in place for staff satisfaction, culture, with action plans e.g., Staff Survey, NQPS, HWB, TED, Cultural survey ○ Leadership and Management Programmes ○ Appraisal and mentoring process ○ Workforce business partner model and advice line in place ○ Staff representatives in place, including union representatives, staff governors ○ Vacancy control panel in place and meeting weekly ○ Strike Action Emergency Planning Group weekly meeting • Equality, Diversity, and Inclusion strategy • Freedom to Speak Up and Guardian of Safe working arrangements	**Gaps in Control** • Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies. ***(GPTW001/DVFM002)*** • Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design. ***(GPTW002)*** • Ability to influence the direction of the Provider Collaborative Board with regards to programmes of work, desired impact measures and methods for achieving aims. • Sufficient staffing within Workforce and OD to support work required to deliver transformation and deliver of the Trust's People Plan	**Assurances** **Internal** • Divisional Governance Structure and Arrangements • Divisional Improvement Forums (including Part II process to address cultural concerns) • Single Improvement Plan impact measures • Raising Concerns Group • Workforce Committee • Education Training and Research Committee • Safety and Quality Committee • Audit Committee assurance processes. • Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board now in place and covered within the Risk Management Policy **External** • National Surveys and benchmarking including staff satisfaction survey, workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) • Internal audit and external reviews.	**Gaps in Assurances** • One LSC performance against standards within supply agreements

• Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan • Communications strategy • Accountability Framework • Safety Forums • New Hospitals Programme • Chief People Officer and Deputy/Associate Directors are present at all People and Transformation Meetings at the Provider Collaborative Board • Supply agreement in place with One LSC		• External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent) • Rostering review by NHSI indicating excellence in rostering practice	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW002	Identify, develop and deliver transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Chief Operating Officer	Identify & develop: 31st December 2024 Deliver: TBC as schemes developed		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.
GPTW003	Strengthen the planning guidance/requirements in relation to transformational workforce schemes and incorporate the identified schemes within the planning cycle/submissions	Director of Strategy and Planning	30th September 2024	30th September 2024	Complete	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Risk updates – October 2024

- Narrative within "Rationale for Current Score" updated to reflect changes following One LSC implementation and impact of vacancy freeze on the workforce.
- Controls updated to note that a Supply Agreement is in place with One LSC
- Gaps in Assurance updated to reflect a lack of assurance around the performance of One LSC against the Supply Agreement
- Action GPTW 003 marked as being complete following update from the Director of Strategy and Planning that the planning cycle for 2025/26 has been reviewed and completed

Risk Title: Risk to delivery of the Trust's Strategic Objective of Fit for the Future

Risk ID: 858
Risk owner: Director of Strategy and Planning/Chief Medical Officer
Date last reviewed: 19th November 2024

Risk

There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

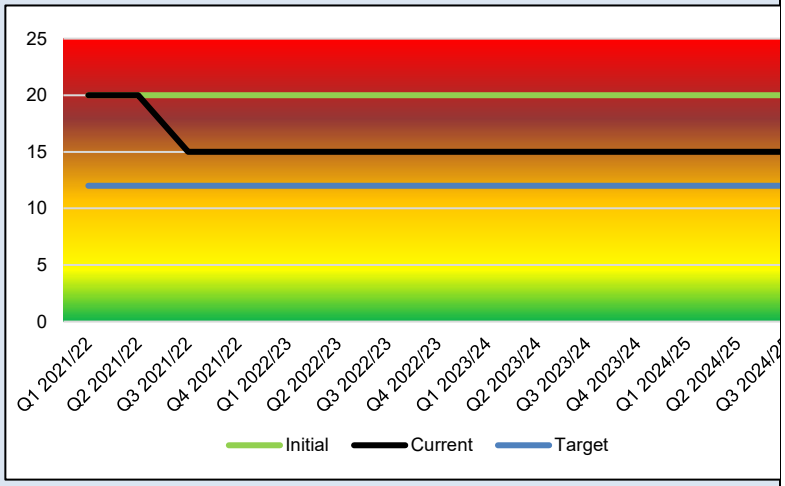
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance
8-12

Rationale for Current Score

- System working continues to develop but further progress is needed at pace in relation to both the governance of decision making and the clarity and confidence in expected benefit delivery. In order for LTH and the wider system to be fit for the future major transformational change is needed. A number of programmes (e.g. Fragile Services, Central Services) are moving forward but challenges and complexity remain in terms of governance, expected benefit plans and programme delivery. The development of a clear system clinical strategy, a clear set of system commissioning intentions and a robust set of LSC transformational programmes are critical to the mitigation of our fit for the future risk.
- Place based working continues to develop, with discussions underway regarding potential budget devolution for 2024/25 and a number of governance pillars/programmes now established such as the Central Lancashire Executive Oversight Group and the Central Locality Community Services Transformation Programme Board. However, there is still significant work to do for LTH and our partners to fully establish transformational Place based governance and work programmes
- Digital transformation will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Northern Star strategy but delivering this will be a major challenge and for a number of reasons our transformational programmes in this are not progressing at the rate we had planned.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet delivery of the services our partners rightly expect and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- Delivering the above will be a major challenge which will require the highest levels of staff engagement and communication, areas where the Trust scores relatively well compared to our peers but we will need significant improvement in future to deliver our ambitions
- Delivering the above will require the Trust to develop its capacity, capability and governance to robustly deliver major change programmes

Risk Rating Tracker (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 3x5 = 15 Target: 8-12



Future Risks

- Demographic pressures
- Population health and Health inequalities challenges
- Estates challenges/backlog maintenance
- Workforce gaps/challenges

Future Opportunities

- System and Place working
- Service transformation/integration
- Digital
- New Hospitals Programme

Controls	Gaps in Control	Assurances	Gaps in Assurances

• LTH establishing a Single Improvement Plan approach, taking best practice from other Trusts/systems drive transformation at pace
• Workstream related strategies in place
  ○ Clinical Strategy
  ○ Digital Strategy,
  ○ Estates Strategy, including New Hospital Programme
  ○ Comms and engagement
• New Hospitals Programme operational groups established and named executive lead.
• Place and system delivery boards established, where LTHTR continue to link own strategies with Place and System plans. A Central Lancashire Executive Oversight Group has been set up and discussions are underway regarding the options for the Lancashire Place Partnership. The ICB have established a new Recovery Board, with a focus on system wide recovery and transformation
• LTHTR executive leads with Place/ICS responsibilities.
• Director of Communications & Engagement and Head of Communications in roles of SRO and Chairs of professional networks and providing significant contribution to the Provider Collaborative
• Clinical Programme Board (CPB) in place meeting monthly overseeing the PCB clinical transformation programme
• ICB has published 5 Year Joint Forward Plan
• Transformation Programmes developed and being led by Executive Team
• Digital Northern Star working groups in place to deliver the Digital Northern Star programme
• Organisations within Digital Northern Star are sharing information regarding infrastructure digital contracts for a collaborative approach to networking and data centres.
• Improved communications Trustwide and External – HeaLTH matters, In Case You Missed It and Exec Q&A session all put in place to enhance staff engagement and External newsletter reinstated for key stakeholders across our communities.
	• Integration of services and pathways. ***(FFTF 006, FFTF 008)***
	• Effective Place and system based working. Work is underway within LTH to review our links into/governance in relation to system working both at the level of individual programmes and at a macro level. ***(FFTF 007, FFTF 008)***
	• Single Improvement Plan approach still under development. (***FFTF 008)***
		Internal
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		• Strategic element of Board discussions has been strengthened with dedicated sessions to focus on specific strategies
		• Northern Star Programme shared approaches developed leading to £1M in cash realising or cost avoidance savings
		• Online presence seen to increase over the period March 2023 – May 2023 with 23,000 new users to the Trust website in that period demonstrating continuing upward trend of engagement with the local population. Increase in Twitter and Facebook interaction and internal intranet interaction also.
		
		External
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
		• Clinical Programme Board
		• Central Services Board
			• Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 008)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
FFTF 001	Link LTHTR strategies with Place, Provider Collaborative and ICS Strategies	Executive Leads	~~5th December 2024~~ 6th February 2025		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Fragile Services programme currently still focussed on a "deficit model" and needs to rapidly develop a robust expected benefits plan
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2024	28th February 2024	Complete	Assurance	• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future
FFTF 003	Ensure maximum LTH influence on/contribution to Place and System working	Executive Leads	30th September 2024	30th September 2024	Complete	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	~~30th September 2024~~ 31st March 2025		Ongoing	Control	• Integration of services and pathways
FFTF 005	Deliver staff engagement/comms strategy (including reputation monitoring/management)	Director of Communication & Engagement and Chief People Officer	30th September 2024	30th September 2024	Complete	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 006	Establish new governance arrangements to support the development of the PCBC in conjunction with the programme office and the ICB	Executive Leads	~~30th November 2024~~ 31st January 2025		Ongoing	Control	• Integration of services and pathways
FFTF 007	Redesign our Social Value Strategy	Chief People Officer	~~31st December 2024~~ 6th February 2025		Ongoing	Control	• Effective Place and system based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	~~30th November 2024~~ 31st December 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Single Improvement Plan approach still under development

Updates – October and November 2024

Risk content reviewed and no change to content required at the current time. Action Plan updates:

- **FFTF 001 - link LTHTR strategies with Place, Provider Collaborative and ICS Strategies –** the Trust has developed our draft Long Term strategy taking full account of national, ICS, PCB and Place Strategies. In particular we have sought to reflect as far as we are able at this stage both the overall ICS Clinical Blueprint/Strasys work and the ICS Urgent Care Strategy and Place based Urgent Care Plan. Whilst the action is marked as complete this will be an ongoing process as the Clinical Blueprint is refined/agreed – however, the key themes within the LTH strategy are unlikely to change materially as a result of this – the "what" is likely to remain as stated; the "how" may result in significant changes to the current operating models in place in L&SC as the strategy is executed**.** The Trust strategy approval will now take place at Board of Directors in February 2025 and therefore the date has been extended to February 2025.
- **FFTF 003 - Ensure maximum LTH influence on/contribution to Place and System working:** LTH have maximised both their influence on and contribution to Place & System working. Several members of the LTH Exec team are SROs for key system work programmes (Elective, Cancer, EPR, Fragile Services etc) and in other areas such as OneLSC and urgent care/out of hospital transformation the LTH Execs and CEO spend significant amounts of time leading and influencing both system and Place. The recent LTH engagement on our draft strategy has enhanced our ability to influence our colleagues at system/place level as they have seen us prioritising and addressing their concerns/priorities. At a PCB level, the LTH CEO has driven the PCB re-set and recently all Trust CEOs have held a development session to share their strategy.
- **FFTF 004 – Develop and deliver Digital Northern Star strategy** OneLSC technical readiness has progressed with a plan for Digital to Tupe in November. The single ICS wide EPR strategy is progressing and development of an ICS wide strategic digital plan framework is underway. This includes mapping over 300 clinical and operational systems that need harmonising across the ICS. Action remains ongoing and is due to be finalised by the end of March 2025.
- **FFTF 005 - Deliver staff engagement/comms strategy (including reputation monitoring/management)** - Stakeholders continue to be informed of key successes and challenges via proactive media activity; series 3 of the Channel 5 documentary Cause of Death; briefings on specific issues; social media activity; Trust Matters Magazine; updates at Board; management of reactive media enquiries and VIP visits including a recent visit by Steve Powys to discuss our thrombectomy service. ITV Granada have filmed a news item on baby loss bereavement week interviewing a family who received fantastic care at the Trust during a seven month stay with us following the birth of their premature triplets one of whom sadly died. Within internal communications key activity has been around the Trust's Financial Recovery Plan and the implementation of the new Single Improvement Plan; the staff survey; vaccinations and the Our People Awards. Our bimonthly All Colleague Team briefs and Senior Leaders Forms continued to provide the opportunity to brief staff on key issues as well as hearing and celebrating their success stories and continue to attract several hundred participants either on the day or watching back online and we have co-ordinated the Pathology Provider Collaborative Briefing on behalf of the PCB. Formal letters have been sent to staff transferring to ONE LSC to advise them of an extension of the consultation process.
- **FFTF 006 - Establish new governance arrangements to support the development of the PCBC in conjunction with the programme office and the ICB –** the new Provider Collaborative Managing Director has now commenced and took a paper to the October PCB meeting laying out a set of actions. The PCB MD has confirmed the following timescales:
    - Executive Committee will be established in November
    - Chairs have been asked to nominate NEDs to join the Assurance Committee and as soon as they are confirmed the PCB will stand the meeting up and run a process to select the chair of the committee
    - The assurance committee will then be asked to review and endorse the ToRs for the respective groups.
    - The professional working groups will be operational from December
    - We will sign off on the formation of the four portfolios in November at PCB and this sign off will also approve the CE leadership arrangements. These new leadership arrangements will be in place from January. Under each portfolio will be a number of programmes each of which will require executive leadership
    - Therefore the reset will ostensibly be complete by the end of January
- **FFTF 007 - Redesign our Social Value Strategy** – Action amended from "Deliver" to "Redesign" of the Social Value Strategy to more accurately reflect the action being taken with an extended due date to February 2025 as the strategy is currently being re-written and will be presented at Trust Management Board (TMB) in December 2024 and then the Board of Directors meeting in February 2025.
- **FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change** – The first draft of our Trust Strategy went to the October Board meeting. The Business Case to review/finalise the recurring resources needed for our PMO will be submitted to the Trust Management Board in December and Finance and Performance Committee in December 2024, therefore the action has been extended.

Risk Title: Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research

Risk ID: 860

Risk owner: Chief People Officer (with input from Deputy Director of Education and Deputy Director of Research & Innovation)

Date last reviewed: 18th September 2024

Risk

There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.

Risk Appetite:

Seek – Eager to be innovative and to choose options offering higher rewards despite inherent business risks.

Risk Tolerance

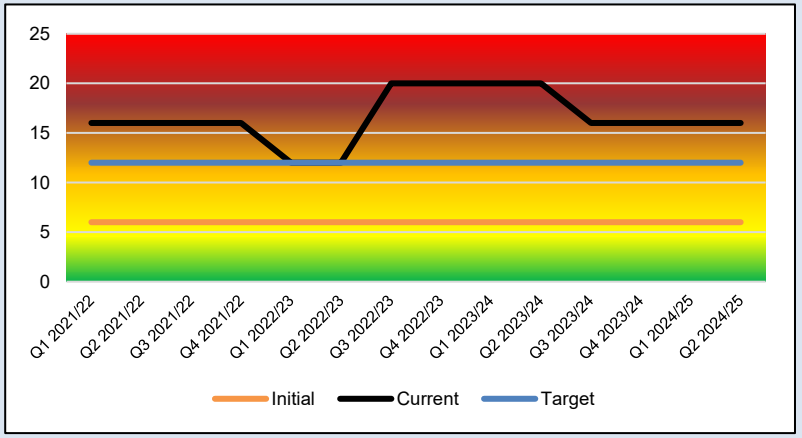
9-12

Rationale for Current Score

- Continuing inability to meet Trust mandatory training targets across all disciplines, which has resulted in continued breaches of CQC regulations.
- A number of areas of Postgraduate Medical Education are being monitored within the NHSE Intensive Support Framework.
- Audit requirements for management of research and educational income limit flexibility to deliver educational activity which is based on academic years or to support innovative developments funded through income generation.
- Inability to invest research and educational income in capital development programmes to expand our education infrastructure.
- Ongoing capacity challenges to support education and R&I activity.
- Workforce shortages impacting on capacity and educational quality.
- Evidence of health and wellbeing concerns in student and learner community.
- Ongoing challenges to achieve optimum faculty for specialist teaching requirements.
- Impact of economic climate/loss of work due to diagnostic/aseptic backlogs and difficulties regarding access to diagnostics across the board to support R&I, notably on commercial research income.
- Not meeting compliance in all training subjects and medical device competencies.
- NIHR guidance changes re commercial work and R&I running at reducing loss, year on year, is assisted by the O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist ongoing mitigation. This will assist reductio of system blockages running too many studies post-pandemic.
- There are opportunities to lead on education, innovation and research programmes in NHP and ICB programmes of work.
- Inability to influence essential release of staff for education activity due to service pressures
- Service pressures impacting availability of staff to be released from clinical environments to attend essential and mandatory education and training.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 2x3= 6 Current: 4x4 = 16 Target: 9-12



Future Risks

- NHSE Long Term Workforce Plan will impact education and training pathways for new and emerging roles.
- Potential impact of OneLSC on Education and Training provision at LTH.
- Capacity for effective marketing and communications.
- Potential impact of the New Hospitals Programme on Education and Research estate.
- Impact of the increased allowance for simulated placements for nursing students delivered by HEIs – this could result in a reduction in NMET tariff income.
- Impact of place-based placement allocation systems (currently emerging) – this could result in a reduction in NMET tariff income.
- UK becoming less competitive/losing commercial research trials
- Impact of UGME capacity scoping exercise being undertaken by NHSE

Future Opportunities

- Continued participation and development of funded, commercial Vaccine Innovation Pathway and UKCRF Network sourced related research activities.
- Expansion of undergraduate programmes.
- Increase in the use of advanced digital/AI solutions to provide education and research programmes.
- Launch of Trust innovation hub and external funding opportunity.
- Development of hi-tech education programmes including robotics and simulation learning.
- Development of joint appointments with HEIs.
- Re-focus of research activity on key national clinical priorities.
- Opportunity to bid for capital to update Health Academies to provide hi tech simulation and education.
- Opportunity for LTH to become apprentice provider for ICS.
- Opportunity to manage income generation via Edovation.
- Potential to expand student placement offer to HEIs within and outside region.
- Provision of a range of educational services to primary care
- Potential to lead a range of education activity as part of ICS shared service development.
- Potential to become Centre of Excellence for Technology Enhanced Learning in partnership with NHSE.

	• Potential income deficit position for education as a result of tariff changes and audit requirements for income deferral • Innovation opportunities may be stifled due to reluctance to accept in-year funding developments where income cannot be flexibly utilised across multiple financial years • Potential impact of shared service development across ICS • Potential reduction in Workforce Development funding and/or potential bid income.	• O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist commercial and financial growth • Aspiration to become a University Hospital • Outcomes from Financial Recovery Plan for R&I

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**
• Workstream related strategies in place: ○ Education & Training Strategy ○ Research Strategy ○ Our Big Plan, Annual Business Plan Planning framework ○ Workforce & OD Strategy • Divisional education contracts. • NHS Education Contract. • Policies in place with review cycle. • Business continuity plans in place. • Head of R&I now part of New Hospitals Programme and ICB programme working parties. • Enhanced plans identified within Research & Innovation Strategy to leverage more opportunity to increase funding and assist recovery processes • Full review of deferred income has been conducted by finance evidencing and ensuring drawdown of income from deferred position/reserves is matched in line with expenditure and the Education Contract on an ongoing basis • Categorised investment requirements for education infrastructure now in place, which is being worked through with Capital Investment Team • International education programmes to be incorporated into 2024-27 strategy.	• Lack of research leads embedded in divisions ***(ETR 007)***	**Internal** • Sub-committees for education, training and research incorporating risk reviews. • Quality assurance and performance management of education activity. • Strategy progress for Research and Education reviewed each year at ETR Committee. • Learner improvement forum. • Monthly training compliance reports. • Divisional performance reviews • Paper to include R&I involvement at DIFs and Divisional Boards has been drafted for approval by the CMO • Monthly finance reviews with corporate finance team and quarterly with R&I budget holders • Education, Training & Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system. • Board. **External** • NHSE Monitoring the Learning Environment review meetings. • Full OFSTED inspection completed August 2022 with 'Good' rating achieved. • ESFA audits • NHSE self-assessment return. • Matrix accreditation. • Annual and interim performance reviews with Manchester Medical School • National Student Surveys. • National Education Trainee Surveys. • STAR accreditation for Clinical Research Facility. • Engagement in range of external forums and committees. • Quarterly strategy meetings with local HEIs • Trust Involvement/leadership in ICS discussions re education and R&I	• Inability to meet Trust Mandatory Training targets across all disciplines across all divisions ***(ETR 008)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 007	Have Research roles in place within 2 Divisions – Suggested Medicine and Women's and Children's Divisions	Head of Research & Innovation	31.03.25		Ongoing	Control	• Lack of research leads embedded in divisions.
ETR 008	Review and consider options to support all disciplines to meet the Trust mandatory training target and ensure reporting provides the necessary assurances, to support regulatory compliance	Deputy Director of Education	~~31.08.24~~ 31.10.24		Ongoing	Assurance	• Inability to meet Trust Mandatory Training targets across all disciplines across all divisions

Summary of Updates – September 2024

- Action ETR 008 – Due date extended. Prototype being developed and version will be presented at ETR for review and will be presented to ETR going forward on a regular basis. Once format is approved at ETR in October 2024, the operational reporting routes will be developed and rolled out across Divisions with plans to be developed to support Divisional and Trustwide reporting formats.

Lancashire Teaching Hospitals
NHS Foundation Trust

Board Assurance Framework

2024/25

How the Board Assurance Framework fits in

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

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

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

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

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

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

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

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

DIRECTOR LEADS	
CEO	Chief Executive Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CNO	Chief Nursing Officer
CPO	Chief People Officer
CMO	Chief Medical Officer
DCE	Director of Communications & Engagement
DSP	Director of Strategy and Planning
DIRI	Director of Improvement, Research & Innovation
CIO	Chief Information Officer

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

Our strategic approach at a glance

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

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

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

Lancashire & South Cumbria New Hospitals Programme

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

Strategic framework
- Patients
- People
- Partnership
- Productivity
- Performance

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

Strategic Objectives

Patients – deliver excellent care
Treating patients with respect and dignity to deliver personalised care and a patient experience of the highest quality.

Performance – deliver timely, effective care
Delivering on key workstreams to achieve standards.

People – be a great place to work
Creating an inclusive environment where people can reach their potential.

Productivity – deliver value for money
Delivering on key workstreams to maximise resources.

Partnerships - be fit for the future
Transforming services and making a positive contribution to our local communities.

2024/25 Corporate Objectives

Patients
- Improve outcomes and prevent harm
- Deliver a positive patient experience
- Develop new ways of working across the system that lead to more effective patient interventions and pathways.

Performance
- To minimise the risk of harm to patients through the delivery of our cancer recovery plan
- To minimise the risk of harm to patients through the delivery of our elective recovery plan
- To improve the responsiveness of urgent and emergency care

People
- To enable better access to care by having the right people, in the right place, in the right number at the right time
- To ensure we improve experience at work by actively listening to our people, and turning understanding into positive action
- To be consciously inclusive in everything we do.

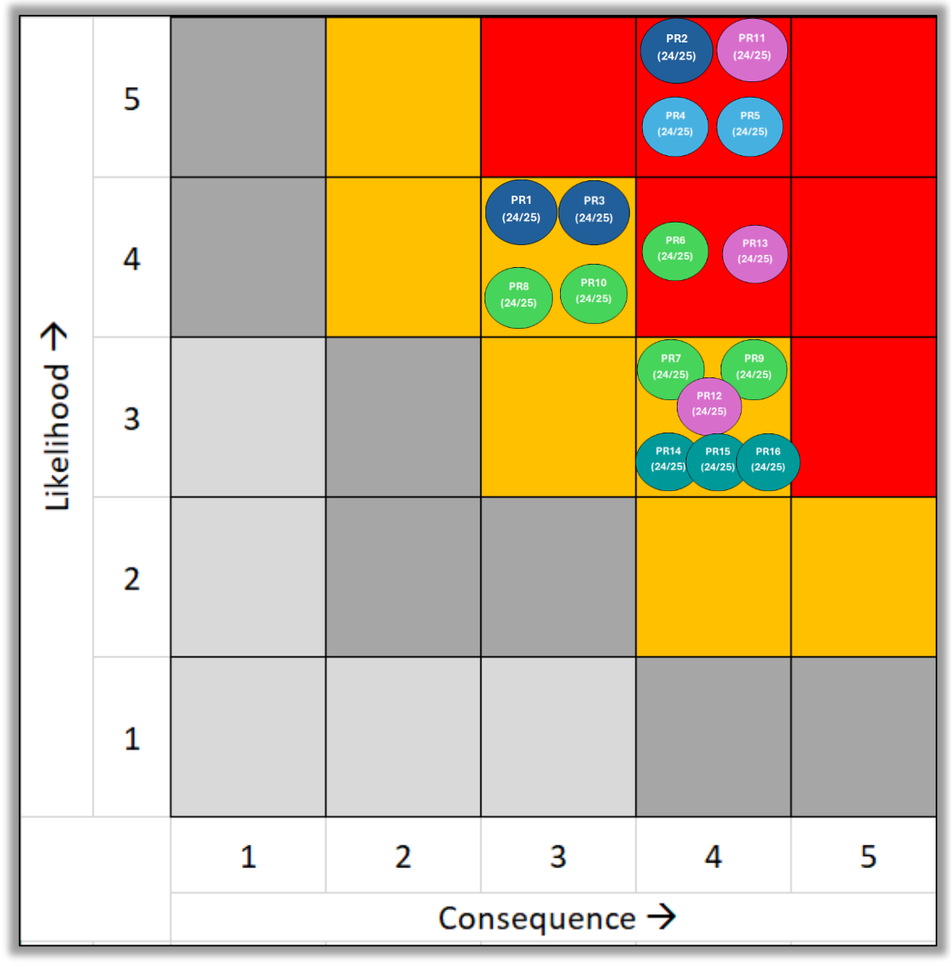
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency

Partnership
- To develop and deliver our plans for the New Hospitals Programme
- To develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable
- To make progress towards our ambition to be a University Teaching Hospital

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
PR1 (24/25)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6
PR2 (24/25)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6
PR3 (24/25)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6
PR4 (24/25)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6
PR5 (24/25)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6
PR6 (24/25)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8
PR7 (24/25)	Experience of under-represented staff groups	CPO	People	WFC	Open	4-8
PR8 (24/25)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8
PR9 (24/25)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8
PR10 (24/25)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8
PR11 (24/25)	Failure to meet the financial plan 2024/25	CFO	Productivity	FPC	Open	8-12
PR12 (24/25)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8-12
PR13 (24/25)	Ability to access required Capital	CFO	Productivity	FPC	Open	8-12
PR14 (24/25)	Readiness for the New Hospital Programme	DSP	Partnership	NHP	Seek	8-12
PR15 (24/25)	Research capacity and capability to enable progress towards University Hospital status	DIRI & CMO	Partnership	ETR	Seek	8-12
PR16 (24/25)	Implementing the long term strategy for the Trust	DSP & CMO	Partnership	FPC	Seek	8-12



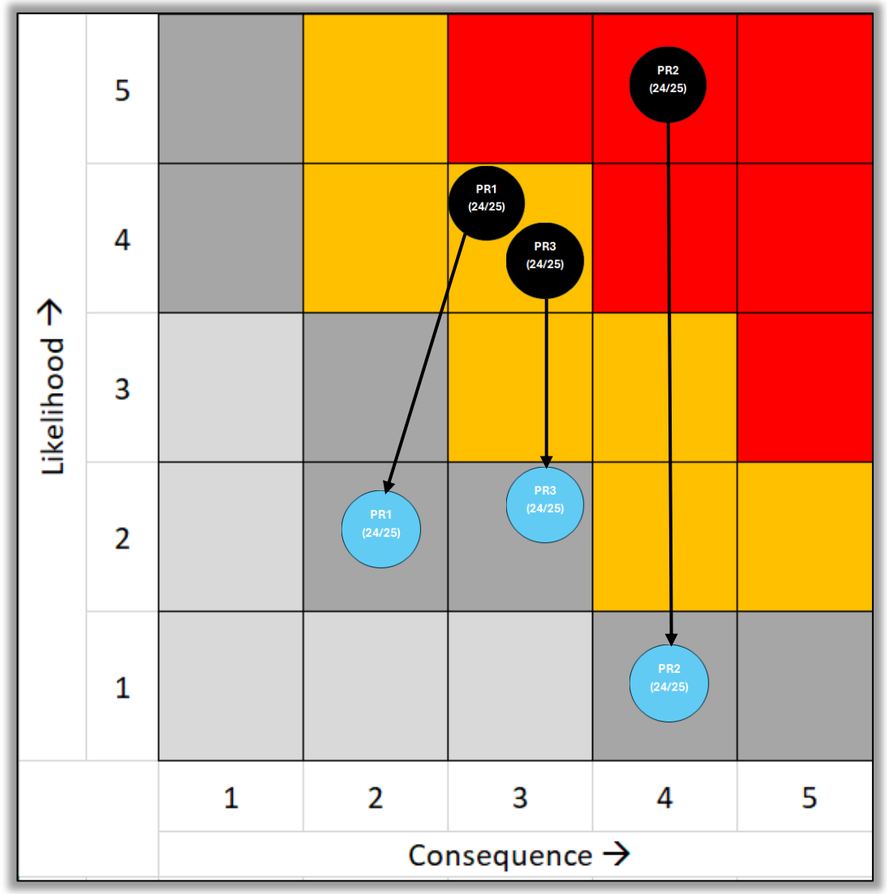
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

The following 2024/25 corporate objectives are aligned to the **Patients** strategic objective:

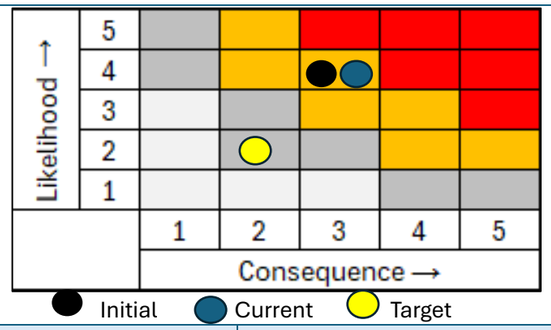
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Review and improve the UEC pathway medical model. • Improvement in average time to see a clinician in ED • Progress in peer review compliance for specialist services. • Develop approach to medical staffing assurance. • Deliver medicines safety and optimisation programme • Lead delivery of CQC action plan • Implement PSIRF & demonstrate maturity in the approach to learning. • Conclude year 3 of the ASF strategy, develop the new ASF and learning strategy, • Deliver agreed C.difficile profile • Deliver 10 CNST safety actions • Deliver annual safe staffing requirements	Risk identified
CO2	Deliver a positive patient experience	• Improve the experience of inpatients, maintain position in ED, cancer and maternity	Risk identified
CO3	To develop new ways of working across the system that lead to more effective patient interventions and pathways.	To deliver more services to patients outside of hospital: • Lead the approach to community transformation • Develop & deliver the community transformation plan • Change model of care at Finney House • Establish new ways of working with primary care to promote partnership approach to transformation • Clinically lead the transformation of patient pathways	Risk identified



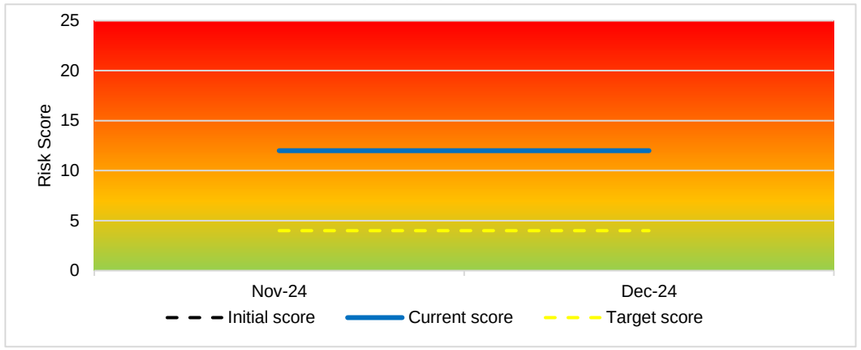
Heat map key: Black = current score, Blue = target score

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

Principal risk 1 (24/25)	Risk Title:	Patient experience within the urgent and emergency care pathway	
	Risk Description:	There is a risk that patient experience within the urgent and emergency care pathway may be negatively impacted due to high service demand, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24



Risk Score Tracker



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

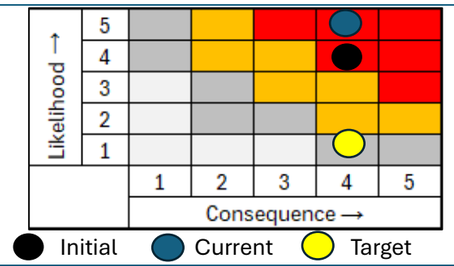
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity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

Risk Treatment

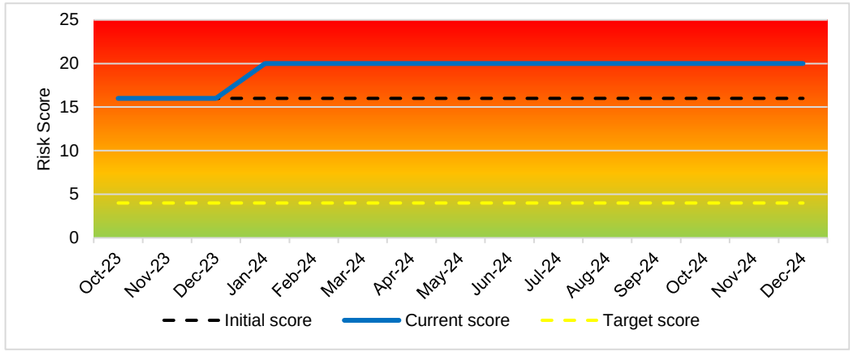
Action	Action Owner	Due Date	Done Date	Action Progress Update
Delivery of Urgent & Emergency Care Picker Survey Action Plan	A. Booth	31.01.25		Monthly meetings in place to monitor progress against the plan.
Nurse staffing plan to respond to times of escalation.	S. Cullen	31.10.24	31.10.24	Complete: Presented to Board and agreed approach to escalation of staffing during escalation to maintain safety.
Review the medical staffing rota requirements for next phase of Consultant and middle grade recruitment.	G. Skailes	31.12.24		Recruitment to key Consultant and middle grade colleagues in progress. Rota requirements being revised to determine model required.
Specialist review of models of care in Emergency and acute medicine requested through NHS England to ensure models in place reflect best practice.	G. Skailes	28.02.25		ED specialist secured, awaiting acute medical lead to be identified and confirm date of review.

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

Principal risk 2 (24/25) (ID 1157)	Risk Title:	Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection	
	Risk Description:	There is a risk that there will be higher than trajectory rates of patients contracting C.*difficile* infection. The reasons for this are multifactorial and present a risk of increased mortality and morbidity, longer length of stay, poor patient experience, regulatory action, and reputational impact.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	09/06/21	Date of last review	26/11/24



Risk Score Tracker



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

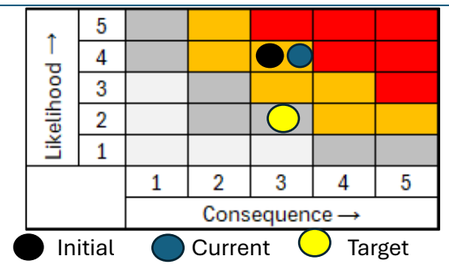
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • IPC Policy in line with national guidance. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in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

Risk Treatment

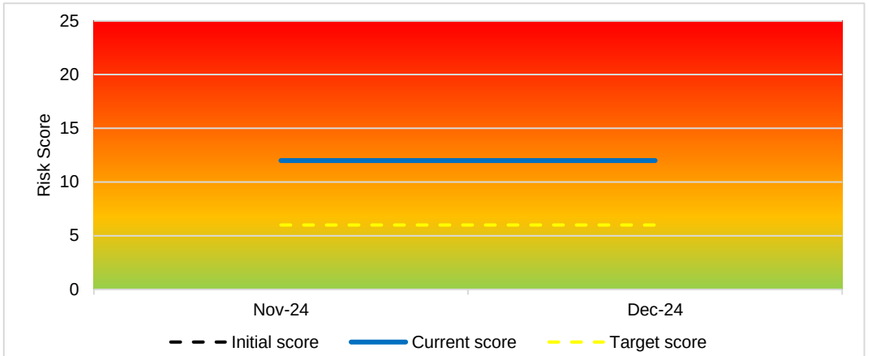
Action	Action Owner	Due Date	Done Date	Action Progress Update
Review the approach to audit for IPC ensuring approach remains efficient and effective.	S Marsh	31.03.25		Meeting planned with DIPC, Matron for IPC and Deputy Chief Nurse to review actions and assurances in relation to audits, red cleans, 'bin the wipes' and 'gloves are off' campaigns to identify if there are any further areas for improvement/assurance.
Write a business case to implement the roll out of National Cleaning Standards in all ward areas.	S Cullen	31.03.25		Business case being written by Deputy Chief Nurse in conjunction with facilities colleagues. This will go through Trust process for approval before being considered as part of budget setting by the Trust Board.

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

Principal risk 3 (24/25)	Risk Title:	People experiencing Health inequalities	
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. • Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. • Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).	• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established.	• 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. • Monthly chairs reporting to Safety & Quality Committee • Bi-annual update on Health inequalities to Safety & Quality Committee.	• Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient's ethnicity either unknown or not stated for Central Lancashire. • Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability.

Risk Treatment

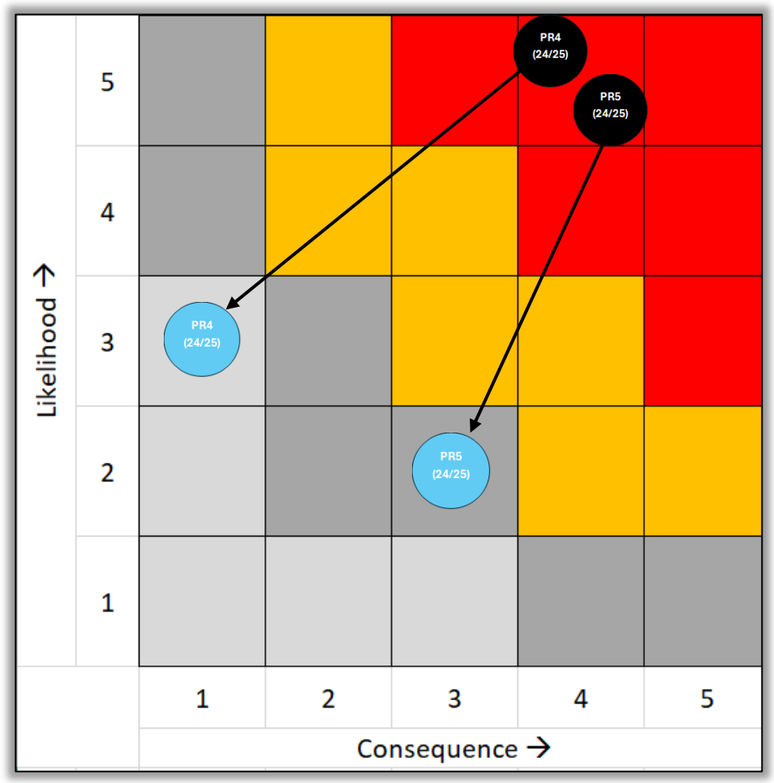
Action	Action Owner	Due Date	Done Date	Action Progress Update
Delivery of the Trust's Health Improvement Plan	S. Cullen	31.03.26		
Finalise Anchor Institute Plan	N. Pease	28.02.25		
Re-commence Anchor Institute Group	N. Pease	31.01.25		
Reviewing options for gap in Public Health Consultant	S. Cullen	31.03.25		
Support case to approve the data sharing agreements between primary and secondary care.	S. Dobson	30.06.25		

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

The following 2024/25 corporate objectives are aligned to the **Performance** strategic objective:

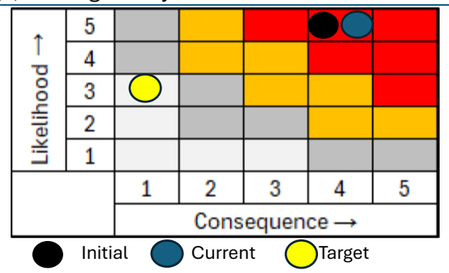
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO4	To minimise the risk of harm to patients through the delivery of our cancer recovery plan	• Delivery of additional elective activity to improve performance against cancer waiting times standards, working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access and working with locality partners to manage demand effectively.	Risk identified
CO5	To minimise the risk of harm to patients through the delivery of our elective recovery plan	• Delivery of additional elective activity to improve performance against elective waiting times standards, working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access and working with locality partners to manage demand effectively.	Risk identified
CO6	To improve the responsiveness of urgent and emergency care	• Working with our partners we will continue to transform urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay.	Risk identified



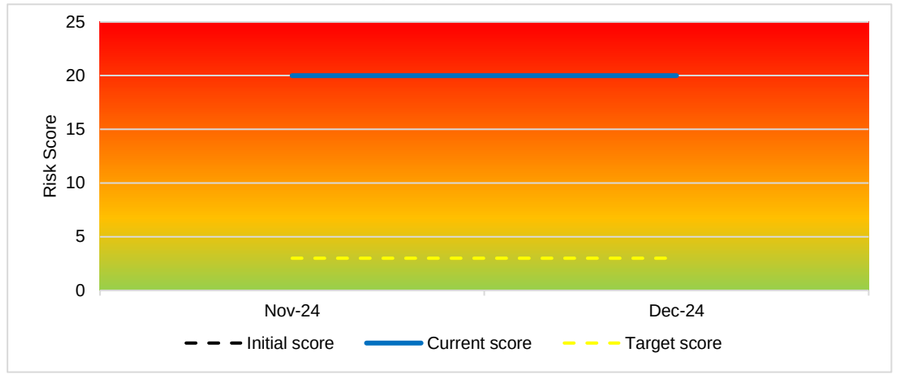
Heat map key: Black = current score, Blue = target score

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

Principal risk 4 (24/25) (ID 1125)	Risk Title:	Timely access to planned and cancer care	
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to planned and cancer care. This is because of backlogs that continue to be seen from the COVID period, surges in demand, shortfalls in capacity, the impact of industrial action, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely access to planned and cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	19/05/21	Date of last review	26/11/24



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Elective Restoration Plans seek to deliver the revised long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. • ChatBot to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. • Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. • A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. • Non-recurrent funding acquired for Winter plans to support and offer resilience for Medicine flow/capacity and thus elective surgery capacity is ringfenced and protected in times of winter/non-elective pressure. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Forecasting of potential breaches for Divisions to proactively focus on patients for review and listing, focusing on month-end 65 week risks as part of the performance recovery group. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Mutual aid process in place with the ICB. • Sherwood Endoscopy Unit opened and additional SGU Theatre in use.	• Lack of detailed sub speciality capacity and demand analysis • Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes • Inability to fully validate waiting lists regularly, • Lack of standardised SOPs for validation. • Shortfalls in funding to support the required capacity to deliver the elective restoration plan • Inability to eliminate extended waits for patients. • National medical employment & terms and conditions, restricting staff working additional hours. • Restricted admin capacity to backfill short notice procedure cancellations.	• Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Live PTL performance report and Validation reports. • Harm reviews process in place for >65 week and cancer pathway patients. • Benchmarking data analysis – model hospital, GIRFT, etc. • Performance monitoring for Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. • DMO1 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Delays in concluding some harm reviews • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Inability to asses the risk for patients on surveillance pathways.

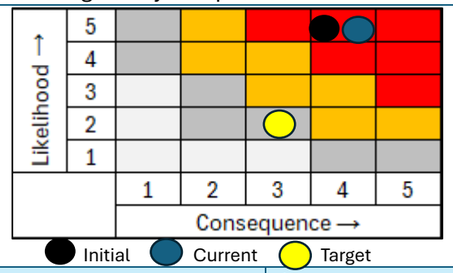
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Strengthen the data quality of opera reporting.	D Hudson	31.12.24		Nov 2024 - Part of the DQ assurance work identified that when generating a pended visit via Opera, the visit was being generated on the incorrect site, necessitating a transfer from one site to the other post admission. Verifying that this has been addressed as part of the Harris Flex roll.
Undertake demand management plans for top 10 specialties in relation to patient initiated follow up and advice and guidance.	K Foster-Greenwood	31.01.25		
Did Not Attend management plan to be scoped and agreed for top 10 specialties	K Foster- Greenwood	31.01.25		
Agree process and timetable for Model Service reviews to triangulate capacity and demand (C&D), benchmarking data and job planning	K Foster-Greenwood	31.12.24		C&D modelling has begun with IST demand templates has been issued to all teams. Model Service programme under development.
Complete capacity and demand modelling for top 10 specialties	K Foster-Greenwood	28.02.25		Neurology commenced Model Service Programme Nov 24. Demand profile for all specialities completed and services are working through capacity analysis.
Phase 1 (Top 10 specialties) capacity mitigation plans including benchmarking analysis	K Foster-Greenwood	28.02.25		

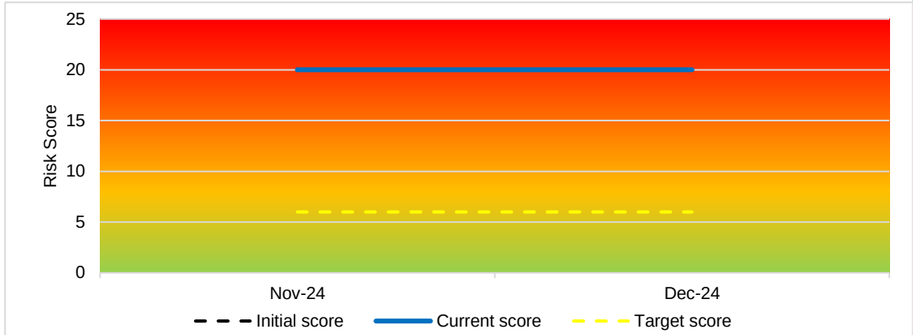
Strategic Objective: Performance	**Corporate Objective:** Improve the responsiveness of urgent and emergency care	Overall Assurance Level	Low

Principal risk 5 (24/25)	Risk Title:	Timely access to urgent and emergency care
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.

Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage process • OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Winter plan. • Ambulatory and admission avoidance pathways. • Same Day Emergency Care facilities. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan. • Discharge Improvement Plan. • Bed meetings and associated action cards • Clinical discharge team management of all patients with no criteria to reside. • Community Healthcare Hub provides a facility for discharge to create capacity in the hospital. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections for social care access to prevent avoidable attendances and admissions.	• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The community healthcare hub medium to long term funding model is yet to be agreed. • The winter plan has identified an unmitigated bed gap. • The environment and estate is sub-optimal.	• Urgent & Emergency Care Board provides monthly monitoring of all improvement actions across the system. • LTH UEC Improvement Board meets monthly and tracks all actions and outcome delivery. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm.	• High bed occupancy levels (above 92%). • Ambulance turnaround times are not meeting the Trust targets. • 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.

Risk Treatment

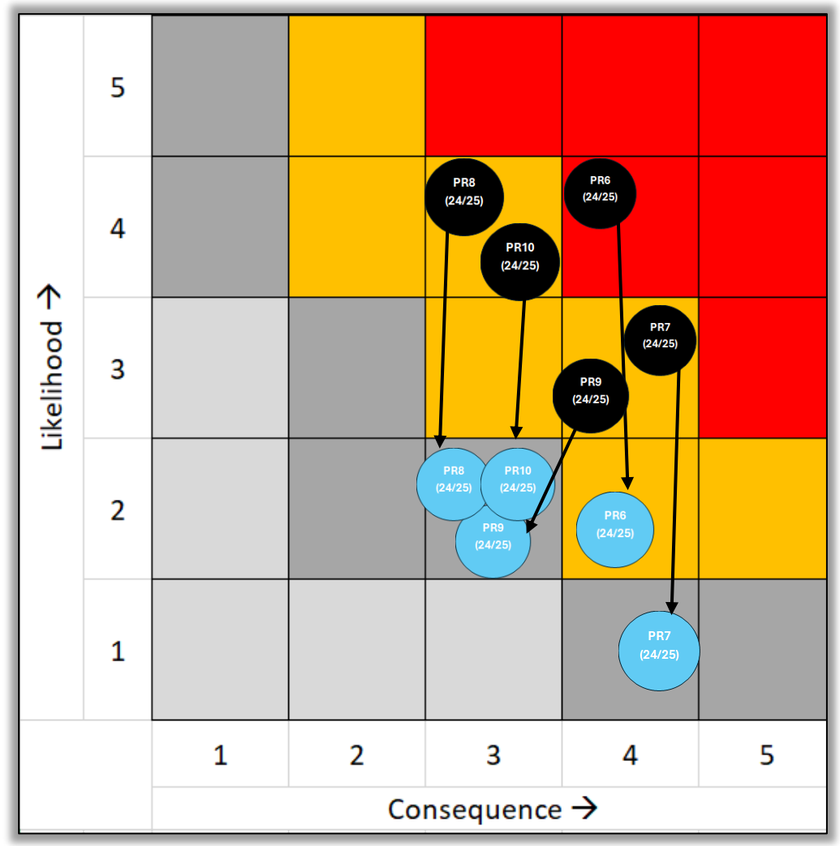
Action	Action Owner	Due Date	Done Date	Action Progress Update
Completion of planned expansion of the surgical assessment unit (SAU).	K. Foster-Greenwood	31.03.25		
Finalise funding approach to Finney House.	S. Cullen	31.01.25		
Expand the volume of Same Day Emergency Care (SDEC) activity.	G Skailes	31.03.25		
Scope and trial the Dr@Door process.	K Challen	31.12.24		Visit to North Manchester General Hospital arranged for Dec 24
Develop a breach allocation by Division methodology and agree improvement plans.	K Foster Greenwood	31.12.24		Draft metrics agreed and shadow monitoring to commence in Dec 24
Implement a Continuous Flow Model.	S. Cullen	31.03.25		CFM mobilised in pilot phase on Ward 23 and AMU Nov 24. Plans to pilot on Ward 18 Dec 24.
Agree Ward and Board round standards and pilot.	S. Cullen	31.12.24		
Agree revised escalation protocols and action cards and implement.	K. Foster Greenwood	31.12.24		
Mobilise Winter Plans.	K. Foster Greenwood	01.01.25		Paediatric schemes mobilised, all others in planning stages.

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

The following 2024/25 corporate objectives are aligned to the **People** strategic objective:

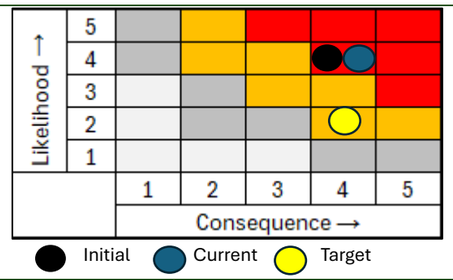
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO7	To enable better access to care by having the right people, in the right place, in the right number at the right time	• To deliver a workforce plan that meets the needs of the community	Risks identified
CO8	To ensure we improve colleagues wellbeing and experience at work by actively listening to our people, and turning understanding into positive action	• To ensure staff choose to stay and work in Lancashire Teaching Hospitals and they are healthy and happy at work	Risks identified
CO9	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care	Risks identified



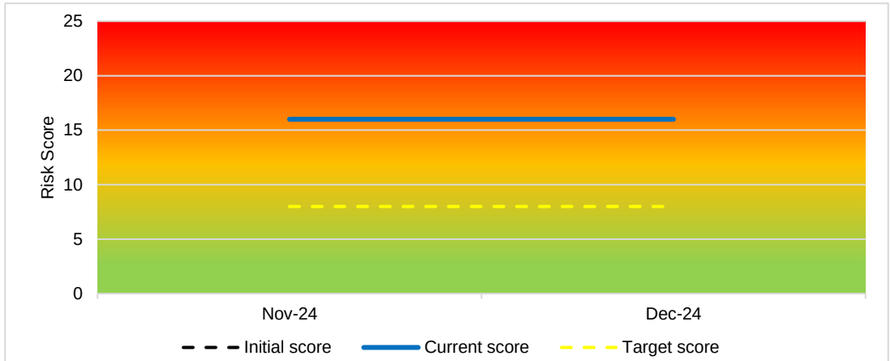
Heat map key: Black = current score, Blue = target score

Strategic Objective: People	**Corporate Objective:** To enable better access to care by having the right people, in the right place, in the right number at the right time	Overall Assurance Level	Medium

Principal risk 6 (24/25)	Risk Title:	Reliance on temporary medical workforce		
	Risk Description:	There is a risk that there may be insufficient numbers of medical staff across the Trust. This is due to increasing capacity and demand, and an inability to recruit to vacancies in some specialities. This could result in a reliance on temporary medical staff, lack of continuity of care, patients not receiving treatment in a timely way, poor outcomes, patient harm, lack of detailed organisational knowledge of processes, poor patient and staff experience, staff working extra hours and an impact on wellbeing, financial impact of enhanced payment rates, regulatory enforcement, legal action and reputational impact.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief Medical Officer	5Ts status	Treat	
Date risk opened	NEW	Date of last review	26/11/24	



Risk Score Tracker



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

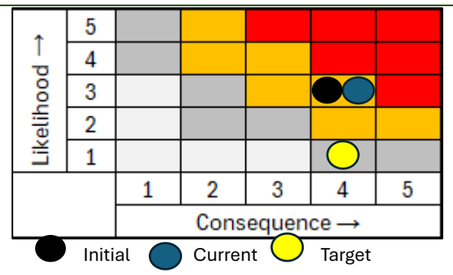
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Healthroster not fully aligned to job plans and when job plans are changed. • Operational capacity and technical ability to monitor 42-week productivity against job plans. • Vacancies in hard to recruit specialities can cause long gaps. • Understanding of speciality-by-speciality minimum safe staffing levels. • Sufficient resource to deliver transformational medical staffing projects.	• Annual Job plan report to Workforce Committee. • Monthly processes in place to review opportunities based on pay activity. • Monitoring of patients seen by a clinician within 14 hours of admission. • Monitoring of patients seen by a clinician following initial assessment.	• Inability to articulate the required medical staffing model. • Inability to report on safe staffing levels in relation to medical staffing in response to CQC must do. • Delays in patients accessing senior medical reviews consistently in all specialties. • Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software. • Requirement to strengthen consistency between ledger and vacancies.

Risk Treatment

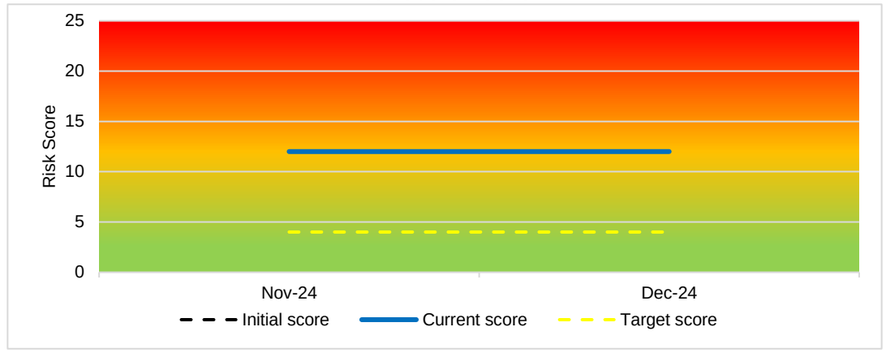
Action	Action Owner	Due Date	Done Date	Action Progress Update
To determine priorities and number of service reviews that will be completed in the Model Service Programme for 25/26	K. Foster-Greenwood	31.03.25		
Agree an approach to determining minimum safe staffing levels	G. Skailes	31.03.25		
Implement actions following ICB Job Plan Programme	G. Skailes	31.03.25		
Review Job Plan Internal Audit outcome when finalised	G. Skailes	31.01.25		
Development of 42-week productivity tool	G. Skailes	31.01.25		

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

Principal risk 7 (24/25)	Risk Title:	Experience of under-represented staff groups	
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues, or prospective employees from under-represented groups. This could result in negative experience for staff, inability to retain a skilled & valued workforce, staff absence, regulatory intervention, and legal action.	
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24



Risk Score Tracker



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

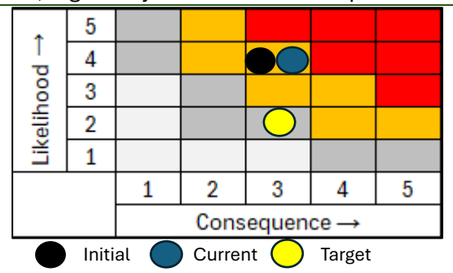
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Equality, Diversity and Inclusion Policy. • Equality, Diversity and Inclusion Strategy. • Single Improvement Plan. • Equality, Diversity and Inclusion mandatory training. • Supporting Disability in the Workplace policy and agreement. • Trans and non-binary policy. • Equality Impact Assessment policy. • NHSE 8 High Impact Actions. • NHS People Promise. • Culture programme, including Zero Tolerance campaigns. • Freedom to Speak Up Policy, Process and Champions. • Employee Relations policies and processes. • Trust Values/Best Version of Us/Leadership in Lancs frameworks. • Core People Management Skills programme. • EDI resources/education/toolkits • Leaders/All Colleague briefings • Staff ambassador forums for colleagues with protected characteristics.	• No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. • ESR Declaration rates for colleagues with a long-term condition or disability. • EQIA process/lack of challenge in respect of EIA findings. • Gaps in localised application of inclusive management practices and in addressing poor behaviours which are not inclusive.	• Equality, Diversity and Inclusion Strategy Group. • L&SC ICS ED&I Group. • Equality, Diversity and Inclusion Strategy monitoring. • Internal Audit review of ED&I in 2023/24 – Substantial Assurance. • Workforce Committee. • Some positive areas identified in the Workforce Race Equality Standards (WRES). • Some positive areas identified in the Workforce Disability Equality Standards (WDES). • North West Anti-Racist Framework. • EDS2022 • North West ED&I Assurance template • Equality Diversity and Inclusion Annual Report	• Areas for improvement identified in the Workforce Race Equality Standards (WRES). • Areas for improvement identified in the Workforce Disability Equality Standards (WDES). • WRES/WDES report only completed on an annual basis • Challenges in ability to drill down into the data from a minority group/divisional basis due to low numbers and confidentiality • Ethnicity Pay Gap/Disability Pay Gap • Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) • EDS2022 – areas for improvement identified

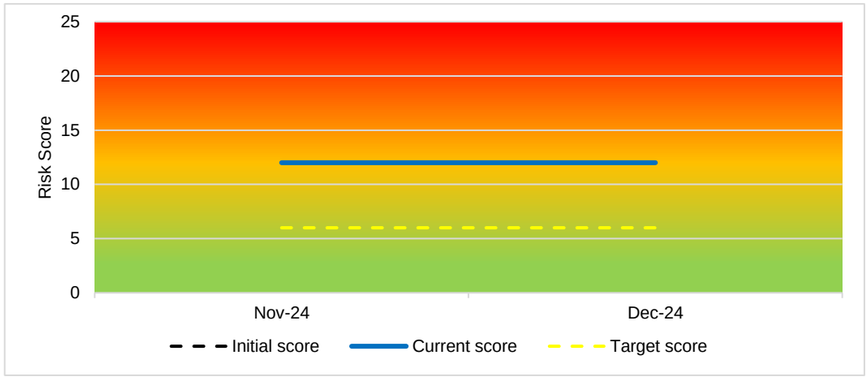
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Reducing the % of colleagues who have not declared disability status on ESR (annual measure)	M. Davis / R. Smith	31.03.25		
Increasing the diversity of colleagues in band 8a< as per WRES/WDES annual report	M. Davis	31.07.25		
Increase level of satisfaction for NHS Staff Survey People Promise element “We are compassionate and inclusive”	M. Davis	31.03.25		
Reducing variation in experience around bullying and harassment for disabled vs non-disabled colleagues	M. Davis / R. Smith	31.03.25		
Reducing variation in experience around discrimination for minority ethnic vs white colleagues	M. Davis / E. Hickman	31.03.25		

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

Principal risk 8 (24/25)	Risk Title:	Sub-optimal experience of Resident Doctors	
	Risk Description:	There is a risk that resident doctors experience of working at the Trust may not always be positive. This is because of operational pressures and working practices. This could result in poor staff experience, grievances, absence, a reduced level of medical staff, inability to recruit, patient safety incidents, regulatory intervention and reputational damage.	
Committee	Education, Training and Research Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24





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

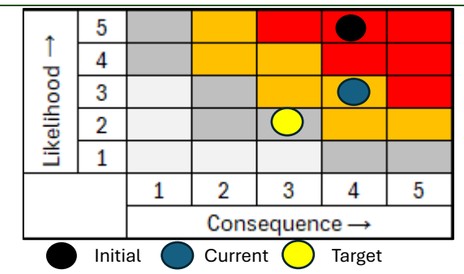
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Resident doctor Single Improvement Plan. • Workforce and OD Strategy. • Education and Training Strategy. • Divisional education contracts. • NHS Education Contract. • Medical Workforce team.	• Lack of national guidance on "Improving the working lives of doctors in training" . • National requirement to take an NHS Staff Survey approach to the GMC National Training Survey. • StatMand training currently under review for all staff groups including resident doctors. • Requirement to work with Lead Employer who holds employment responsibilities for resident doctors. • Time restriction of Lead Medical Education officer to progress the resident doctor agenda. There is a need to identify an accountable officer for responsibility of improving the working lives of doctors	• Education, Training and Research Committee. • Workforce Committee. • Divisional Workforce Committee. • Resident doctor forum. • Exception Reporting. • Raising Concerns. • NHSE Monitoring the Learning Environment quarterly meetings. • GMC National Training Survey (NTS). • National Education and Training Survey. • Annual Internal Placement Experience.	• Gap in triangulation of GMC National Training Survey into Raising Concerns, Exception Reporting and NHS Staff Survey Reporting • GMC National Training Survey 2024 results indicated that Trust performance is marginally below the national average in 14 out of 18 themes. • A number of areas of Post Graduate Medical Education are currently being monitored within the NHSE Intensive Support Framework • Lack of NHS Staff Survey level of analysis and corporate level action plan for GMC national training survey NTS and National Education and Training Survey for resident doctors, with insufficient triangulation of themes and organisational and specialty level.

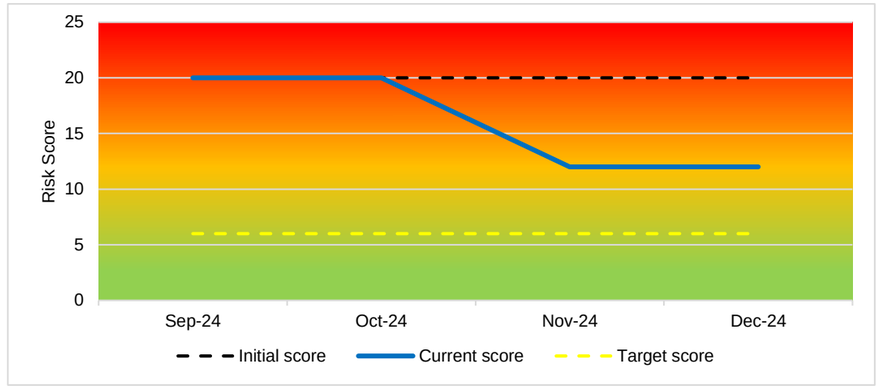
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Review current structures within Education to identify dedicated Medical Education leadership role	L. O'Brien	31.12.24		
Identify opportunity to develop resident doctor SIP group, including identification of Chair	L. O'Brien	31.12.24		
Review educational governance processes to determine where resources relating to the design and delivery of corporate and specialty level interventions sit	L. O'Brien	31.01.25		
Review Education and Training Strategy	L. O'Brien	31.03.25		

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

Principal risk 9 (24/25)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates			
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.			
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8		
Director	Chief People Officer	5Ts status	Treat		
Date risk opened	10/02/14	Date of last review	26/11/24		





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

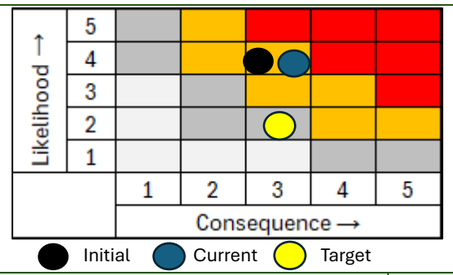
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Sickness Absence Policy in place. • Core People Management Skills training in place. • Monthly reports to Divisions - check & challenge. • Accountability Framework in place which has recently been refreshed. • Toolkits and templates for Managers. • "What Good Looks Like" for Managers. • Live data & reports in Health Roster. • Workforce Advisor Support in place (although at an insufficient level) • Health & Wellbeing Strategy in place. • Workforce & Organisational Development Strategy in place. • Operational processes in place Divisionally to look at staffing levels. • Dashboards in rosters to see safe staffing levels. • Rostering guidance and support in place.	• Gaps in localised management practices. • Lack of one complete absence record affecting ability to demonstrate policy compliance. • Insufficient capacity within the Workforce team to support absence management as proactively as possible. • Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. • Lack of triangulated data to support prediction/notice of warning signs for sickness absence. • Insufficient capacity within the psychological wellbeing service.	• Workforce Committee. • Divisional Workforce Committees. • Divisional Improvement Forums review absence levels. • 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.	• Inability to achieve the 4% target. • Internal audit of sickness absence management practices, (October 2024) provided limited assurance. • Currently a manual process to monitor compliance with absence management policy and processes.

Risk Treatment

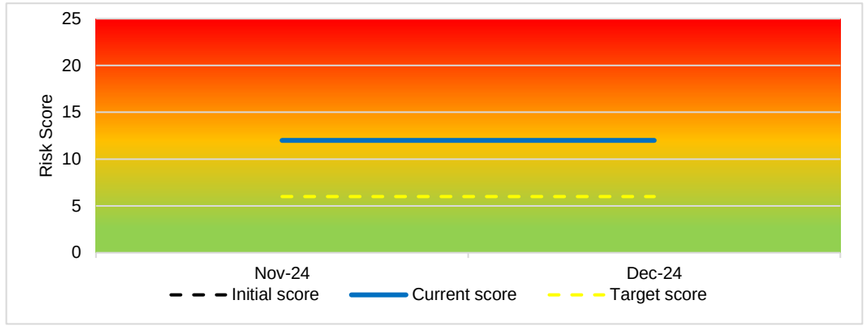
Action	Action Owner	Due Date	Done Date	Action Progress Update
Pilot Empactis as a digital absence management system	R. O'Brien	31.12.24		
Continuous Improvement programme for Workforce Advice Team to support improvement of absence management across the Trust	R. O'Brien	31.12.24		
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	31.12.24		
Develop business case for additional psychologist	R. O'Brien	31.12.24		

Strategic Objective: People	**Corporate Objective:** To enable better access to care by having the right people, in the right place, in the right number at the right time	Overall Assurance Level	Medium

Principal risk 10 (24/25) (ID 2041)	Risk Title:	Compliance with Core Skills Training & Appraisals		
	Risk Description:	There is a risk that staff may not have received the core skills training required for their role or had an appraisal in the Trust-defined timeframes. This is due to unavailability of staff, time and capacity. This could result in staff not having up to competencies, patient safety incidents, poor patient experience, poor staff experience, regulatory action, claims and complaints.		
Committee	Education, Training & Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	NEW	Date of last review	26/11/24	



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Core skills training framework (CSTF). • Training needs analysis. • Corporate Induction process. • Local Induction process. • Appraisal Policy. • Appraisal Policy for Medical and Dental colleagues. • Accountability Framework. • Self-service e-learning and appraisal platform. • Regular review of target audiences with Clinical Educators and Divisional leadership. • Training Compliance and Assurance Sub-Committee govern any proposed changes to Core Skills topics. • Monthly emails to staff to show compliance with training and appraisals and any areas that are due to expire. • Weekly reminder to staff who are out of date with Core Skills training. • 'Super red' tool produced to support the divisions in identifying staff who have more than 1 super red topic. • Monthly meetings take place between Training Performance and Compliance and Divisional Nursing Directors to review target audiences and complete approval for sign off of any changes.	• Gaps in localised application of appraisal policy and processes. • Nationally set Core Skills training framework. • National review of Core Skills Training Framework (CSTF), which is reviewing statutory and mandatory training across all Trusts, with a plan to produce a national StatMand framework in 2025. This could increase / change the requirements for delivery of training nationally and the governance processes.	• Training & Appraisal Compliance report - produced monthly and sent to divisional and corporate leaders. • Regular provisions and/or presentation of compliance including Core Skills training report to Divisional Workforce Committees. • Reports to Training, Compliance and Assurance sub-committee. • Training and Appraisal reports to Divisional Improvement Forums. • Bi-monthly Education Training and Research committee reports to escalate gaps and assurances in plans to rectify. • Annual Appraisal Strategic Update report to Workforce Committee. • Integrated Board Performance Report. • NHS Staff Survey Results	• The Trust is currently non-compliant with specific mandatory (core skills training framework) & essential training subjects as reported to ETR Committee. • The Trust are not meeting the target for appraisal rates. • The training reports currently provided do not map directly to CQC core services, or by professional group.

Risk Treatment

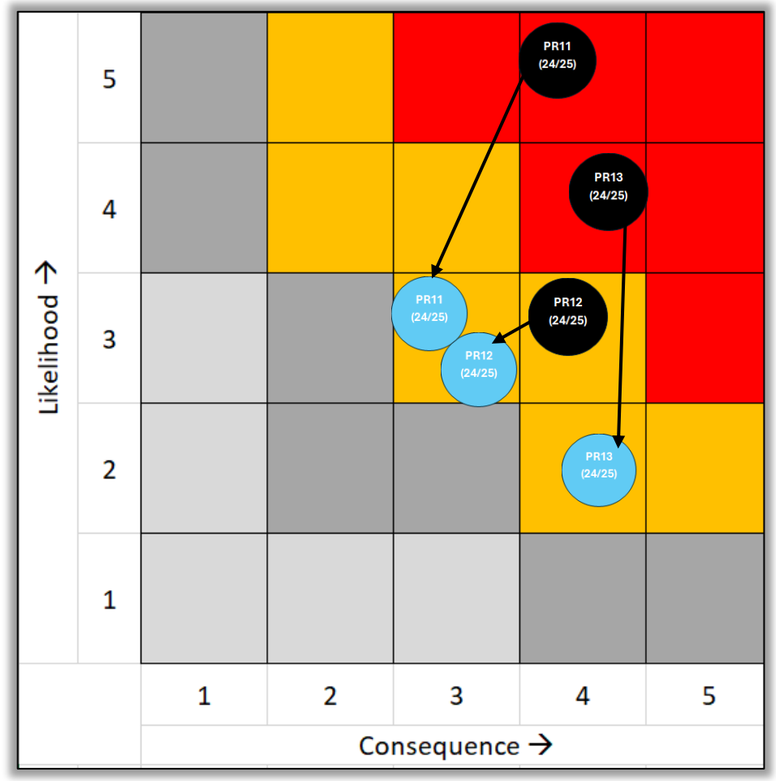
Action	Action Owner	Due Date	Done Date	Action Progress Update
Training & appraisal data being re-aligned to CQC Core Services	L. O'Brien	13.12.24		
Detailed reporting to Divisional Improvement Forums for colleagues that have not attended training	L. O'Brien	13.12.24		
Review Mandatory Training Policy	L. O'Brien	31.01.25		
Review Appraisal Policy	L. Graham	31.12.24		
Review Appraisal Policy for Medical & Dental colleagues	J. Anderton / D. Kellet	28.02.25		
Reviewing processes including guidance provided on how to complete appraisals, reviewing appraisal forms, monitoring and QA processes and developing intranet information hub.	L. Graham	31.03.25		
Reviewing and updating appraiser training	L. Graham	30.01.25		

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

The following 2024/25 corporate objectives are aligned to the **Productivity** strategic objective

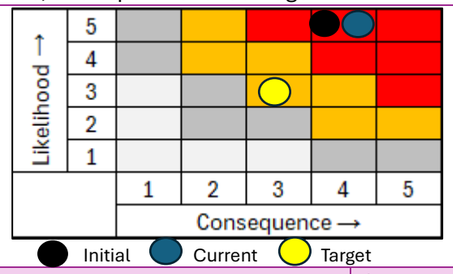
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO10	To provide value for money services by spending less, spending well and spending wisely	• To evidence improved value for money and delivery of the financial recovery programme.	Risks identified
CO11	To deliver sustained improvement evidenced through the single improvement plan	• To deliver against the plan and demonstrate this as improved outcomes for the organisation.	No risks identified
CO12	Improve our underlying productivity and efficiency	• To maximise our productivity through the delivery of our FRP, SIP and other transformation plans.	No risks identified



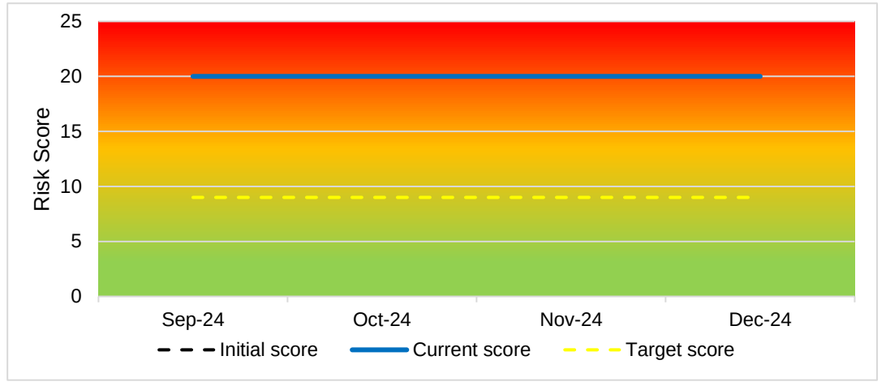
Heat map key: Black = current score, Blue = target score

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

Principal risk 11 (24/25) (ID 1557)	Risk Title:	Failure to meet the financial plan in 2024/25	
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2024/25. 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, further regulatory intervention, impact on staff experience, and reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	25/11/24



Risk Score Tracker



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

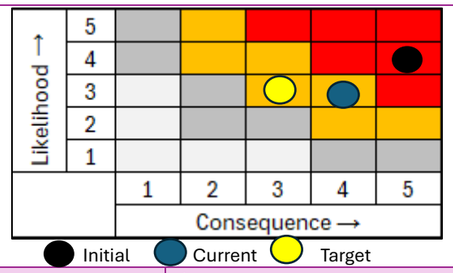
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. • Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. • There are a suite of pay controls for filling vacancies and using agencies. • Processes are in place to ensure financial recovery plan (FRP) schemes that are delivered are transacted through the ledger. • There are a range of grip and control measures in place for managing discretionary expenditure. • There is a no PO no pay system in place for managing non pay expenditure.	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • The savings programme alongside additional control measures is currently failing to deliver the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 25/26. • Fully embedded PMO to support the divisions to deliver the financial recovery plan. • Operational pressures limiting management capacity.	• 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. • Risks identified monthly to Finance and Performance committee. • Internal Audit - on the integrity of financial systems - through Audit Committee. • External Audit - on the financial accounts - through Audit Committee. • Ledger reconciliations - on the integrity of the financial data. • Variance and trend analysis - on the integrity of the financial data. • Collaborative working in ICS - integrity of financial data.	• The Trust is reporting a forecast year end variance to financial plan driven principally by under delivery of our savings programme. The deterioration of our forecast has resulted in escalated scrutiny from NHSE and the I&I improvement lead. • Development of the transformation agenda is required to support delivery of the FRP. • There is insufficient understanding of the plan to address productivity shortfalls.

Risk Treatment

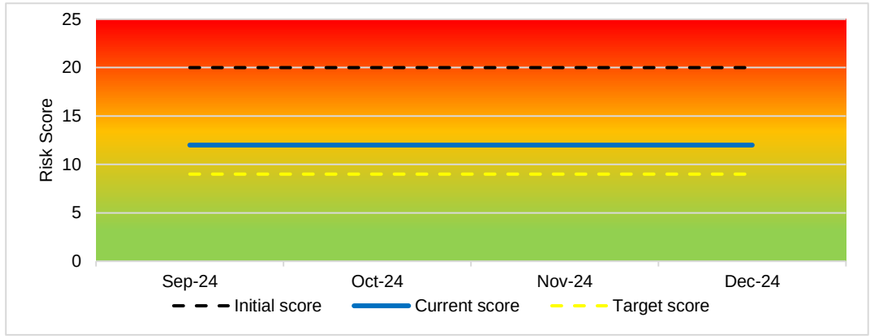
Action	Action Owner	Due Date	Done Date	Action Progress Update
Implementation of grip and control activities from Investigate and Intervene system review	C. McGourty	31.01.25		Nov 2024 - Enhanced vacancy firebreak put into place with oversight from CEO. Medicine Rapid improvement weeks undertaken with 4 speciality business units. Plan to embed this and roll out to other divisions and specialities.
Business Case to review/finalise the recurring resources needed for Trust project management office.	G. Doherty / A. Brotherton	31.12.24		Nov 2024 - will be submitted to the Trust Management Board in December and Finance and Performance Committee in December 2024

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

Principal risk 12 (24/25) (ID 802)	Risk Title:	Cash consequences of the Trust's underlying financial position	
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	25/11/24



Risk Score Tracker



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

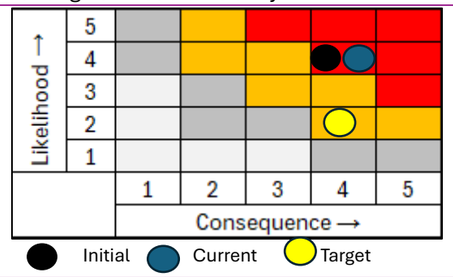
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts.	• Levels of understanding of the cash consequences of not using the established ordering processes. • Access to cash support is subject to external approval.	• Internal Audit reporting through Audit Committee. • Monthly reporting of position including KPIs to Finance & Performance Committee. • Monitoring and reporting performance against 30-day deadline for payments.	• Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. • Drop in performance against 30-day deadline for payments.

Risk Treatment

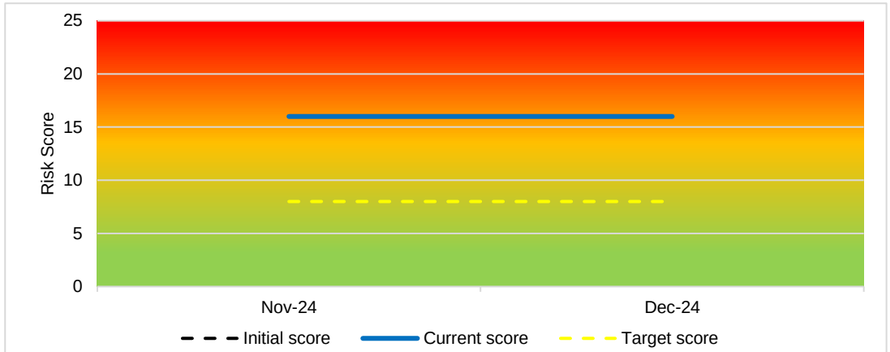
Action	Action Owner	Due Date	Done Date	Action Progress Update
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	31.03.25		Nov-24 Update: Request made in August 2024. To be monitored ongoing
Establish Cash Management Committee to oversee cash flow forecasting, sensitivity analysis and the development of mitigation plans.	C. McGourty	30.11.24		Nov-24 Update: Plan to be established by the end of November 2024

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

Principal risk 13 (24/25)	Risk Title:	Ability to access required Capital	
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • Capital Planning Forum review and determine risk-based approach and recommendations. • Capital Plan agreed by Executive Team & Trust Board. • Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. • Medical Equipment Group with clinical input to support risk assessment and prioritisation. • IT provided with a budget from Capital Planning forum. • Contingency budget identified at the start of the financial year. • Emergency capital funding process for extreme situations. • Identification of national funding 'bid opportunities'. • Standing financial instructions. • Standing Orders. • Scheme of Reservation and Delegation.	• Externally set capital allocation. • External capital bid opportunities have short timeframes and ability to fully cost this is limited by operational capacity. • Impact of inflation in terms of project costs and timescales. • Ageing estate and inability to comply with latest statutory guidance. • Estates Strategy not finalised. • Approach to IT allocations requires review. • Inability to replace medical equipment as required.	• 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. • Asset register in place to support oversight of medical equipment. • Medical Device report to Safety & Quality Committee. • Capital update to Finance & Performance Committee.	• Significant backlog maintenance. • Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind). • Tracking of project overruns and underspend. • Governance around contract change notices. • Contingency budget is at risk of being exhausted at month 8 of the financial year indicating a potential risk should contingency be required.

Risk Treatment

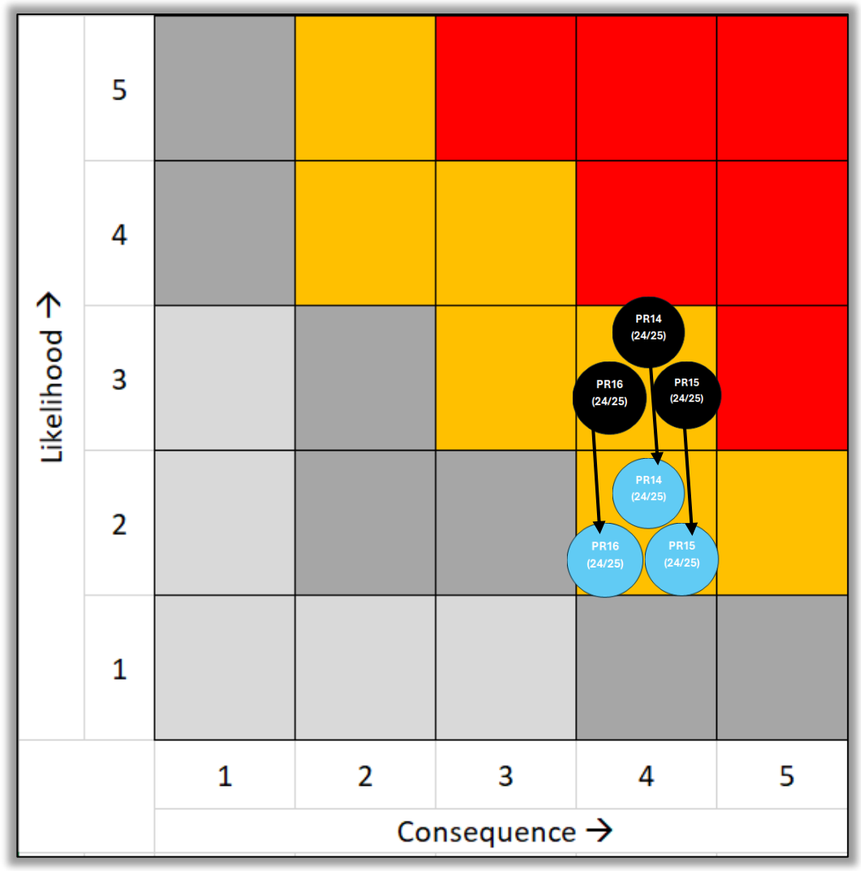
Action	Action Owner	Due Date	Done Date	Action Progress Update
Develop Estates Strategy	C. Howell	28.02.25		
Review and propose alternative options for capital funding allocations	B. Patel	31.03.26		
Review and improve governance of contract change notices	B. Patel / C. Howell	31.03.25		
Review approach to management and reporting of project spend at Capital Planning Forum	D. Stonehouse	31.07.25		

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2024/25 corporate objectives are aligned to the **Partnership** strategic objective:

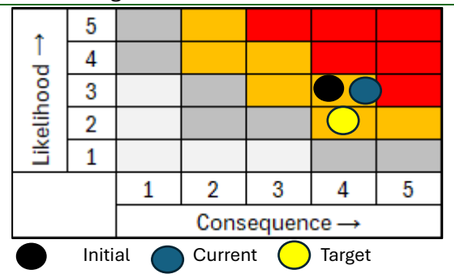
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO13	To develop and deliver our plans for the New Hospitals Programme	• Ensure the successful delivery of our once in a lifetime opportunity to deliver a New Hospital for the residents of Central Lancashire and Lancashire and South Cumbria	Risk identified
CO14	To develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable	• Deliver plans for OneLSC and develop and implement agreed clinical service strategies/plans • As an Anchor Institution, work with partners to improve population health, supporting development of a thriving local economy and reducing health inequalities.	Risk identified
CO15	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status	Risk identified

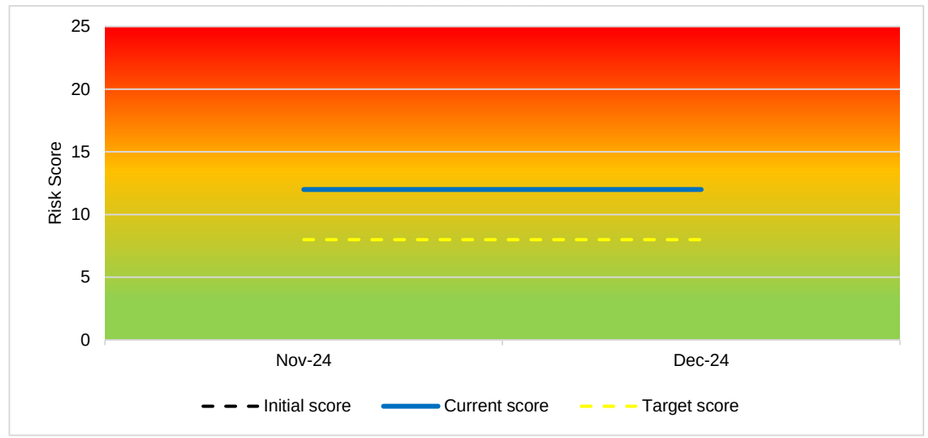


Heat map key: Black = current score, Blue = target score

Strategic Objective: Partnership	**Corporate Objective:** To develop and deliver our plans for the New Hospitals Programme	Overall Assurance Level	Medium

Principal risk 14 (24/25)	Risk Title:	Readiness for the New Hospital Programme	
	Risk Description:	There is a risk that the New Hospital may be delayed because of a lack of agreement on future clinical strategies across Lancashire & South Cumbria, insufficient delivery of transformation, and the inability to secure an appropriate site. This could result in risks to the deliverability/success of the project and right sizing a new hospital, project timeline delays, increased overall costs, as well as a loss of confidence among stakeholders.	
Committee	New Hospital Programme Committee	Risk Appetite and Tolerance	Seek 9-12
Director	Director of Strategy & Planning	5Ts status	Treat
Date risk opened	NEW	Date of last review	26/11/24





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

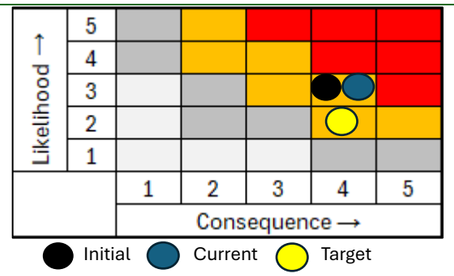
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Framework model of care for the Trust has been developed. • Established links between NHP and transforming community care programme to understand out of hospital provision. • New Hospital LTHTR master plan which identifies dependencies with transforming community care. • L&SC NHP demand and capacity modelling completed (2021). • Monitoring of demand and capacity assumptions against delivery trajectories. • Governance structure in place across the L&SC system to review products, timeline, risks and dependencies.	• Land for the new hospital is yet to be acquired. • Delivery plans for transforming community care are yet to be aligned with NHP demand and capacity assumptions. • National NHP demand and capacity exercise underway and due to conclude in Q4 2024/25 which may impact programme assumptions.	• Framework model of care signed off within Programme Governance. • Trust Board development sessions held on L&SC NHP baseline demand and capacity assumptions.	• Output of the national demand and capacity exercise is ongoing and will require review to understand the impact/actions required.

Risk Treatment

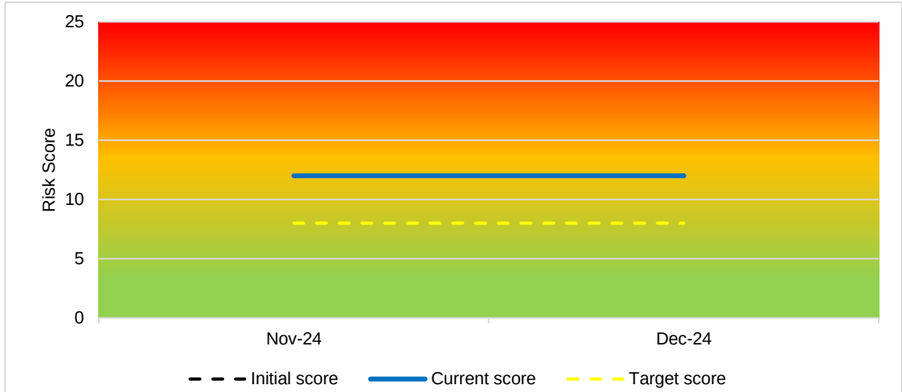
Action	Action Owner	Due Date	Done Date	Action Progress Update
Identification and acquisition of land for New Hospital	Programme Director	31.03.25		In progress
Following acquisition, undertake engagement on proposed site location	Programme Director	31.03.25		Start date to be determined based on previous action

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

Principal risk 15 (24/25)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status		
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.		
Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12	
Director	Director of Improvement, Research and Innovation, and Chief Medical Officer	5Ts status	Treat	
Date risk opened	NEW	Date of last review	26/11/24	



Risk Score Tracker



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

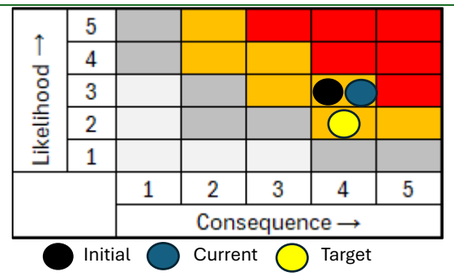
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Fixed National Institute of Health & Care Research (NIHR) Income. • Research & Innovation Strategy (2022-25). • Some protected job-planned time for clinical research activity. • Quarterly Research Collaborative meetings with the 2 main LSC universities to develop research opportunities. • Some joint appointments with university partners.	• Historical and current overspend of research budget. • Funding available to increase capacity and capability. • Ability to engage medical colleagues in in different academic specialities to support advances in research in those areas. • Strategy and appetite of universities to invest in clinical or other academic roles to be based at the Trust.	• Bi-annual Research & Innovation Strategy update. • Research & Innovation Committee. • Education, Training & Research Committee. • Integral role in ICS R&I Collaborative.	• Income generation plan for financial recovery plan is behind trajectory. • Initial project plan to develop partnerships not currently agreed and therefore progress is not able to be reported to R&I Committee and ETR Committee. • Universities are experiencing similar budget constraints and so may lack ability to invest in these areas.

Risk Treatment

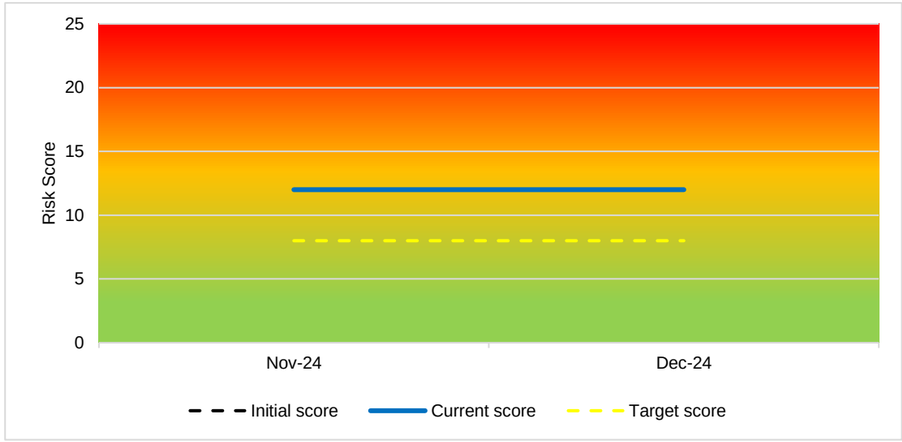
Action	Action Owner	Due Date	Done Date	Action Progress Update
Delivery of the Income recovery plan for R&I	P. Brown	31.03.25		
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown	28.02.25		

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

Principal risk 16 (24/25)	Risk Title:	Implementing the long term strategy for the Trust		
	Risk Description:	There is a risk that the implementation of the long term strategy for the Trust may be hindered because of lack of alignment with system partners, clear commissioning intentions, insufficient clarity/strength within our processes for system governance/change, resource limitations, and potential resistance to change. This could result in delays in achieving the objectives, fragmented service delivery, reduced quality of patient care, increased costs and inefficiencies across the healthcare system, and failure to improve health outcomes for the population.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Seek 9-12	
Director	Director of Strategy/Chief Medical Officer	5Ts status	Treat	
Date risk opened	NEW	Date of last review	26/11/24	



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire and South Cumbria (L&SC) Integrated Care System (ICS) joint NHS forward plan and Clinical Blueprint • System Improvement Board • Three-year Single Improvement Plan • Trust's Annual Corporate Objectives • Provider Collaborative Board Joint Committee (PCB JC) • Place based working • Trust development/integration plans with LSCFT	• L&SC Clinical Blueprint has been developed but we are not yet at the stage where we have a detailed, agreed implementation plan. • Discussions with external partners regarding greater service/pathway integration still need further development and may be impacted by the discussions/plans with respect to the L&SC Clinical Blueprint. • Trust long term strategy not yet finalised • Draft ICB Commissioning intentions have been shared but more discussion needed to agree the implications for the Trust. • The 2024 Darzi Review has given a clear indication of the issues to be addressed in the NHS, and some indication of the likely actions needed, but the new long term NHS strategy will not be released until 2025/26. • System based working is still evolving/improving e.g. the PCB Governance reset is underway but has not been fully implemented and Place based working is still developing.	• Finance & Performance Committee system updates • Trust Board discussions/papers • Trust Board workshops/seminars	• Finalised Trust long term strategy

Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Agree final Trust long term strategy	G. Doherty / A. Brotherton	28.02.25		Final draft is on track to be approved at February Board
Fully implement PCB Reset	PCB JC	28.02.25		Reset is underway
Finalise implementation plan for the LSC Clinical Blueprint	ICB / PCBJC	31.03.25		Discussions are underway across LSC e.g. Trust Board discussion is scheduled for December 2024.
Agree the implementation plan for the ICB 2025/26 Commissioning Intentions	ICFO / G. Doherty	31.03.25		Discussions are underway

Risk Appetite Scale

Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust
Seek	Eager to be innovative and to choose options offering higher rewards, despite inherent business risk
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Cautious	Preference for safe delivery options which have a low degree of residual risk and only a limited reward potential
Minimal	Preference for very safe delivery options which have a low degree of inherent risk and only a limited reward potential
None	Avoidance of risks is a key organisational objective

*Created in conjunction with Good Governance Improvement (GGI)

Risk Matrix

Lancashire Teaching Hospitals
NHS Foundation Trust

Risk Rating Matrix (Likelihood x Consequence)

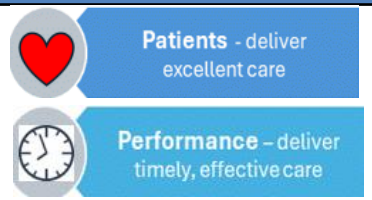
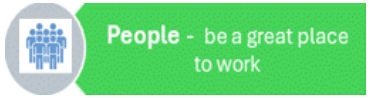
Likelihood ↑		1 Neglible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain	5 Moderate	10 Significant	15 High	20 High	25 High
	4 Likely	4 Moderate	8 Significant	12 Significant	16 High	20 High
	3 Possible	3 Low	6 Moderate	9 Significant	12 Significant	15 High
	2 Unlikely	2 Low	4 Moderate	6 Moderate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

Derived from National Patient Safety Agency Risk Matrix

Appendix 5 - Proposals for Risk Appetite and Tolerance Update

Lancashire Teaching Hospitals NHS Foundation Trust

- Recommend:
  - Risk Appetites are aligned with current appetite and tolerances agreed at the start of 2024/25 where there is a direct alignment with those agreed at the start of 2024/25.
  - New Strategic Objective for 'Performance – deliver timely, effective care' is aligned with the appetite and tolerance for 'Patients – deliver excellent care' given the correlation with this strategic objective.
  - Risk appetite statement is updated in line with these revisions.

Current Strategic Risks		Current Risk Appetite	Current Risk Tolerance	Strategic Objective (5 P's)	Proposed Risk Appetite	Proposed Risk Tolerance
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &…	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	Cautious	1-6		Cautious	1-6
	Risk to delivery of Strategic Ambition: A Great Place to Work	Open	4-8		Open	4-8
	Risk to delivery of Strategic Ambition: Deliver Value for Money	Open	8-12		Open	8-12
	Risk to delivery of Strategic Ambition: Fit for the Future	Seek	8-12		Seek	8-12

9. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY)

9.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Smyth | 13:40

Item for assurance

REFERENCES

Only PDFs are attached

09.1 - Safety and Quality Committee - 27 Sept and 25 October 2024 Chairs Report.pdf

Chair's Report to Board		
Chair: Non-Executive Director Ms Kate Smyth	**Safety and Quality Committee**	
Date: 27 September 2024 & 25 October 2024	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• **Maternity and Neonatal Annual Staffing Report**

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	The Continued non-compliance of national cleaning standards. The analysis now evidenced that non-compliance and frequency of cleaning has positively led to a reduction in C.difficile rates. The consideration of the business case to implement this will be included as part of the budget setting for 2025/26. The registered midwife component of the Birthrate plus recommendation requires funding as part of the 2025/26 budget setting. The Winter Planning Paper 24/25 outlined a strategy to attempt to address the anticipated bed gap during the winter period. The paper identified the risks associated with an increased demand over the winter period which was calculated to result in a bed deficit. The Committee had concerns that the bed deficit was a high risk for patients on the UEC pathway. The Urgent and Emergency Care picker survey outlined that the Trust position had deteriorated regarding the experience of patients in the UEC pathway. A plan was presented to the committee that is dependant on the wider UEC plan delivering the aims it sets out. It was acknowledged by the committee that the position regarding the boarding of patients is having an adverse impact on patients and staff throughout the UEC pathway.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	The nationally mandated Health Inequalities data for 2023/24 was welcomed by the Committee. The data would be used to develop the Health Inequalities Plan and be published on the website in line with guidance. The Committee confirmed it was assured of the progress report against the Always Safety First Strategy 2021-24. Key successes include: - Implementation of PSIRF, including recruitment to patient safety partners - Delivery of 10 CNST actions for maternity - Implementation of safety surveillance systems for wards and emergency departments, supporting high level oversight of real time safety measures - Improvement in the national staff survey on safety focused questions - 1480 people have complete continuous improvement

	- Micro Coaching Academy (MCA) has now trained 132 colleagues as coaches and is underway with cohort 8. - Flow Coaching Academy (FCA) has trained 94 coaches - As at end of March 2024, the cumulative ward engagement in the MCA improvement programme is 61 clinical areas with 132 individuals trained in leading improvement methodology. - Learning disability training level 1 (including Oliver McGowan training outcomes) - Safety training implemented and compliant - Reduction in missed medication doses - Increase in reporting compliments by 45% - Commenced patient safety visits on a monthly basis - Completion of Magnet study and maintained international learning relationship with Hackensack Hospitals - NGPod Global trial led to a 77% reduction in X-ray and 39% improvement in the immediate bedside decisions to feed. - Introduction of call for concern (Marthas rule) The Committee received the results of the National Cancer Patient Experience Survey for Lancashire Teaching Hospitals. The survey results were published 24 July 2024. The overall score for care at the Trust was 9 out of 10, which had been sustained for three years and was above national average. The National Maternity Picker Survey demonstrated an improved position with higher than average performance. The areas that require improvement link to the Birthrate plus staffing investment regarding induction of labour. The Central Alert System Assurance report provided an overview of the Trust's Safety Alert Management up to 10 October 2024. The Committee noted the unresolved safety alert for Sodium Valproate and Topiramate. The ICB had been unable to secure funding for resources to support the referrals received by the Trust. The CMO would continue to liaise to identify a solution.
ASSURE **Assurance received; Matters of positive note.**	The committee received assurance reports relating to: - Annual Maternity Staffing - Winter Planning - Thrombectomy 7 day service - Maternity Picker Survey - Medicines governance - Health Inequalities - Equality Quality Impact Assessment Report The reports provided an overview of areas of strength and areas that required continued focus.

	The Committee received assurance in relation to the ward 8 outcome measures. The leadership changes were demonstrating signs of improvements in key metric compliance data and staff sickness absence. The Committee received assurance in relation to the Thrombectomy service. Further discussion with the Interventional neuroradiologists had reached an agreement that from 3 August 2024, the weekend thrombectomy service would be resumed. The Equality and Quality Impact Assessment report provided assurance on the status of assessments for quarter 1 April 2024 to June 2024 and quarter 2 July 2024 to September 2024.

Safety and Quality Committee

27 September 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 30 August 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Annual Maternity Staffing Report.	1.05pm	✓	Assurance	J Lambert
7.3	Children and Young People Staffing Report	1.20pm	✓	Assurance	S Cullen
7.4	Health Inequalities Report	1.30pm	✓	Assurance	S Cullen
7.5	Winter Plan	1.40pm	✓	Assurance	K Foster-Greenwood
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	1.55pm	Verbal	Decision	K Smyth
8.2	Items to alert, advise or assure the Board	2.00pm	Verbal	Information	K Smyth
8.3	Reflections on the meeting and adherence to the Board Compact	2.10pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Always Safety First Learning and Improvement Group e) Medicines Governance Committee f) Patient Experience and Involvement g) Health Inequalities Group – no meeting		✓		
9.3	Date, time and venue of next meeting: *25 October 2024, 12.30pm, Microsoft Teams*	2.15pm	Verbal	Information	K Smyth

Safety and Quality Committee

25 October 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 27 September 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Children and Young People Staffing Report	1.00pm	✓	Assurance	S Cullen
7.3	Maternity Picker Survey	1.10pm	✓	Assurance	J Lambert
7.4	UEC Picker Survey	1.20pm	✓	Information	S Cullen
7.5	Cancer Picker Survey	1.30pm	✓	Information	A Tomlinson
7.6	Always Safety First Strategy 2021-24	1.40pm	✓	Assurance	C Gregory
7.7	Winter Plan	1.50pm	✓	Assurance	K Foster-Greenwood
7.8	Equality Quality Impact Assessment Report	2.00pm	✓	Assurance	S Cullen
7.9	Thrombectomy Service Update	2.10pm	✓	Assurance	G Skailes
8.	GOVERNANCE AND COMPLIANCE				
8.1	Central Alert System Assurance Report	2.20pm	✓	Assurance	S Regan
8.2	Strategic risk register review	2.30pm	Verbal	Decision	K Smyth
8.3	Items to alert, advise or assure the Board.	2.35pm	Verbal	Information	K Smyth

№	Item	Time	Encl.	Purpose	Presenter
8.4	Reflections on the meeting and adherence to the Board Compact	2.40pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	**Terms of Reference:** a) Mortality and End of Life Care Committee		✓		
9.2	Exception report from Divisional Improvement Forums		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee e) Patient Experience and Involvement **f)** Health Inequalities Group **– no meeting** g) Health and Safety Governance h) Mortality and End of Life Committee		✓		
9.4	Date, time and venue of next meeting: *29 November 2024, 12.30pm, Microsoft Teams*	2.45pm	Verbal	Information	K Smyth

9.2 MATERNITY AND NEONATAL SERVICES REPORT

Other | J Lambert | 13:50

Item for assurance

REFERENCES

Only PDFs are attached

09.2 - Maternity and Neonatal Safety Report - Board of Directors Final.pdf

Board of Directors

Maternity and Neonatal Services Safety Report

Report to:	Board of Directors	**Date:**	05/12/2024
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert

Purpose of Report

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

Executive Summary:

The purpose of this report is to provide the Board of Directors with an update in relation to safe staffing and the safety and quality and assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) within the maternity and neonatal services up until June 2024. In addition, where appropriate obstetric medical and neonatal updates are included in the report for cross triangulation and information)

In November 2024, the CNST progress within the service was validated by the local Maternity and Neonatal System LMNS and signed off against 7/10 of the standards for the MIS. The remaining 3/10 standards are on track to meet the recommendations but cannot be signed off until the end of the reporting period which ends on the 30 November 2024. (See Appendix 1 CNST MIS Information Pack). The final position will be available and presented in the next report.

The perinatal quality surveillance outcomes (PQSO) supplementary information pack is included in Appendix 2. The PQSO pack provides an overview of the key safety intelligence associated with safe staffing, clinical indicators, perinatal quality experience, regulation, and clinical escalation. This ensures that there is understanding and oversight of key performance and that check, and challenge is applied when appropriate. Appendix 2 provides the data pack for the CNST MIS standards.

The perinatal quality surveillance data indicates some areas of pressure. Red flags associated with delay in review by an obstetrician in maternity triage continue to be the highest reporting category. Data in the report confirms that at weekends and out of hours is the largest proportion of time when delays occur and is the priority area of focus to consider.

Clinical indicators which are showing positive performance relate to antenatal booking and perineal tears. Interventions to improve performance in these areas show signs of being effective. Key actions have been added to the Dashboard to indicate when an improvement or change has been made for reference.

The service confirms the outcome of the safe staffing review which was presented to the Board of Directors in October 2024. 6.68 WTE have been approved for consideration in the April 2025 planning round. This will align the service with the 2022 Birth Rate Plus requirements.

Close monitoring of the establishment is ongoing. The vacancy is currently 5.9 WTE. The ability to recruit has been delayed by the additional measures of oversight that are in place associated with the financial recovery plan. However, all vacancies are now out to advert. The fill rates for Registered Midwives (RM) (94%-day, 92% night) and Maternity Support Workers (MSW) (77% day and 96% night) in October 2024 demonstrates an improving position overall, which is synonymous with the reduction in established midwifery vacancies. The lower-than-expected fill rates for support workers during the day is attributed to long term sickness on maternity A (3.5 WTE) which equates to 66% of the unregistered establishment.

As part of responding to the staffing establishment within the unit, the service continues to move colleagues around the service as required to meet demand and utilises bank and agency as required. Divert arrangements are enacted when appropriate and whilst this mitigates the risk to women, when it occurs, this can adversely affect the experience of women who live locally and have chosen to give birth in Lancashire and south Cumbria.

On the 20 November 2024 NHS Resolution wrote to the Trust to confirm that the thematic review of cases reported by the Trust to the Early Notification (EN) scheme between 1st April 2017 and 29th February 2024 is now complete. In the letter, it was confirmed that they were satisfied with the detailed evidence of learning and completed actions provided by the service. (See appendix 5).

The service confirms a stable position overall resulting from the improved midwifery staff in post and the stable leadership from the substantive obstetric workforce. Work continues on the for induction of labour and maternity triage workstreams and improving obstetric cover out of hours and at the weekend needs to be the priority.

RECOMMENDATIONS

The Committee is asked to:

I. Approve the Maternity and Neonatal Service Update, noting its consideration and endorsement by the Safety and Quality committee.
II. Note the CNST update report and recommendations.
III. Confirm it is satisfied a comprehensive level of check and challenge has been applied by the Board level safety champions to understand the performance and pressures affecting the maternity and neonatal service and reflect this in the committee minutes.
IV. Receive the supplementary information pack and associated action plans for oversight and assurance**.**

Appendices

1. CNST MIS Information Pack standards 1-10
2. Perinatal Quality Surveillance Supplementary Pack
3. Red Flags
4. Induction of labour Quarter 2 findings
5. NHS Resolution Outcome Letter

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place to Work	☒

To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For the Future	☒
Previous consideration			
29.11.24			

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work and present the monthly staffing position within the maternity and neonatal services. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators for Board assurance and oversight.

2. MATERNITY INCENTIVE SCHEME (MIS)

The ten MIS safety actions continue to drive standards for safer maternity and neonatal care based on NHS England's long-term plan to reduce stillbirth rates, maternal morbidity, neonatal mortality and serious brain injury by 50% by 2025.

A summary of the position and progress for CNST MIS year 6 is detailed below. (Table 1). In November 2024, the CNST standards were validated by the local Maternity and Neonatal System LMNS and signed off against 7/10 standards. The remaining 3/10 standards are on track to meet the recommendations but cannot be signed off until the end of the reporting period which ends on the 30 November 2024. (See Appendix 1 CNST MIS Information Pack)

Table 1 Details the status of all 10 safety actions and includes supporting information to maintain or achieve the standard.

	Description	Progress	Evidence	Status
Safety Action 1 PMRT	**ARE YOU USING THE NATIONAL PERINATAL MORTALITY REVIEW TOOL (PMRT) TO REVIEW PERINATAL DEATHS FROM 8 DECEMBER 2023 TO 30 NOVEMBER 2024 TO THE REQUIRED STANDARD?**	Since 8th December 2023, there were 21 cases reported, 17 of which were eligible for PMRT review. All cases were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month of the death. The service is on track to meet the defined thresholds for multi-disciplinary reviews using the PMRT, where 95% are started within two months of the death, and a minimum of 60% of multi-disciplinary reviews are completed and published within six months. As action plans are collated these will be added to future iterations for oversight. **Standard 1 cannot be signed off until after the 30 November 2024 following the end of the reporting period.**	Appendix 1. Table 1,2 and 3	On track
A weekly failsafe report is generated to confirm that all standards are met. This is supported by a weekly failsafe meeting overseen by the matron for safety and quality.				
Safety Action 2 MSDS	**ARE YOU SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?**	The service has consistently achieved 11 out of 11 CQIMs since 2022 and data integration continues to be undertaken and monitored monthly. This includes valid ethnic category (Mother) for at least 90% of women booked in the month. The service confirms that validation of data submissions relating to activity in July 2024 has been undertaken and the MIS standards have been met for year 6.	Appendix 1 Table 4	Validated
A data report is generated and checked prior to submission of the MSDS data, and this is confirmed at a monthly data meeting by work stream leads.				

Safety Action 3 Transitional Care	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE THAT YOU HAVE TRANSITIONAL CARE SERVICES IN PLACE AND UNDERTAKE A QUALITY IMPROVEMENT TO MINIMISE SEPARATION OF PARENTS AND THEIR BABIES?	Pathways of care into transitional care and Avoiding Term admissions to the neonatal unit (ATAIN) continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams and guidance is in place which supports a care pathway from 34+0 in alignment with the BAPM Transitional Care (TC) Framework for Practice. The division continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care. A Quality Improvement (QI) initiative to reduce separation related to thermoregulation is ongoing as defined by MIS year 6.	Shared in previous reports	Validated
The Working better together joint multiprofessional group undertakes review of all term admissions (ATAIN) to the neonatal unit and monitors transitional care (TC) activity. TC and ATAIN dashboards are generated, and a quarterly report is submitted to speciality maternity and neonatal safety and quality committee for oversight. This is shared with the LMNS and ICB on a cycle of business.				
Safety Action 4 Workforce	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF CLINICAL WORKFORCE PLANNING TO THE REQUIRED STANDARD?	**Obstetric Workforce**. There has been significant investment in the obstetric consultant roles and leadership. Business case is being collated for 2 tier model and an obstetric workforce action plan is ongoing.	Shared in previous reports	Validated
		Neonatal Medical A local workforce review of the neonatal medical staffing requirement to achieve British Association of BAPM standards was undertaken in 2023. Realignment of job plans, and use of the ORDER programme means that from February 2025 a 1:8 rota for all grades will be achieved. This will enable the neonatal service to declare BAPM compliance.	Shared in previous reports	Validated
		Neonatal Nursing: The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report which was published 2023/24. The report confirms that the service has enough nurses within the establishment to be compliant to BAPM standards based on the average activity for the previous 3 years.	Shared in previous reports	Validated
		Anaesthetic To comply with the anaesthetic medical workforce requirements associated with CNST year 6, a copy of the anaesthetic rota for all months during the reporting period is held as evidence for monitoring purposes by the service, confirming that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. To date the service is 100% compliant with this standard.	Shared in previous reports	Validated
The Board of Directors are accountable for ensuring the fundamental quality standards are delivered, including having the appropriate workforce to deliver safe care. To meet the standard requirements for the obstetric medical workforce, regular audits and reviews are undertaken to provide assurance.				
Safety Action 5	Description	Progress	Evidence Source	Status

Midwifery Staffing	**CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?**	The second safe staffing report for 2024 was presented to the Board of Directors in October 2024. The funding to meet the requirements of Birth Rtae plus (6.68 WTE was approved and will be enacted as part of the financial planning round in 25/26.	Bi-annual Safe staffing repots April and October 2024	Validated
Safety Action 6. Saving Babies Lives V3 (SBLV3)	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE THAT YOU ARE ON TRACK TO ACHIEVE COMPLIANCE WITH ALL ELEMENTS OF THE SAVING BABIES' LIVES CARE BUNDLE VERSION THREE (SBLV3)?	The service continues to make progress against the 5 elements of the SBLV3 care bundle and is 91% compliant with the 70 cumulative actions. The service confirms that two (with a third planned) quarterly quality improvement discussions have taken place, and that sufficient progress has been made with full implementation of the care bundle. Therefore, the standard was externally verified by the LMNS/ Integrated Care Board in November 2024.	Appendix 1 Table 5	Validated
There is a programme of improvement work focused on SBLV3, each of the 6 elements has a named obstetric or medical lead. Areas of focus and actions are detailed in appendix 2. The Continuous improvement plan				
Safety Action 7	Description	Progress	Evidence Source	Status
	LISTEN TO WOMEN, PARENTS AND FAMILIES USING MATERNITY AND NEONATAL SERVICES AND COPRODUCE SERVICES WITH USERS.	The Maternity and Neonatal Voices Partnership (MNVP) and the maternity and neonatal services continue to work on the priorities defined within the joint work plan into 2024. Quarterly MNVP meetings continue to be held between service users and providers to collect safety intelligence and feedback in line with MIS year 6.	Appendix 1 Table 6	Validated
The MNVP lead and Deputy Divisional Midwifery and Nurse Director meet monthly to review priorities and action feedback. The MNVP lead attends maternity and neonatal safety champions and safety and quality committee as key membership. (As defined in MID year 5 and 6.				
Safety Action 8	Description	Progress	Evidence Source	Status
	CAN YOU EVIDENCE THE FOLLOWING 3 ELEMENTS OF LOCAL TRAINING PLANS AND 'IN-HOUSE', ONE DAY MULTI PROFESSIONAL TRAINING?	The service confirms that the full Training Needs Analysis (TNA) standards continue to be fully aligned with version 2 of the Core Competency Framework (CCF) and the programme of training has been shared with the Divisional Safety Champions and MNVP lead. **PROMPT** Compliance with PROMPT – over 90% overall with an action plan in place for 2 new starters in anaesthetics who have not yet undertaken training in PROMPT. In line with MIS year 6 updated standards, they must have attended by the end of February 2025. Compliance will be tracked by maternity safety and quality committee and be confirmed in later iterations of this report **BASIC NEONATAL LIFE SUPPORT** Compliance of the neonatal and medical newborn life support is tracked in line with MIS year 6. 90% achieved overall including midwifery neonatal medical and nursing. **FETAL MONITORING** – over 90% achieved in all required staff groups 97% overall. **Standard 8 cannot be signed off until after the 30 November 2024 following the end of the reporting period.**	Appendix 1 Table 7	On Track
Training requirements are tracked via maternity safety and quality monthly, and actions taken to ensure all staff groups have achieved 90% by the end of the reporting period. All staff groups defined in the CCF V2 are 90% for fetal monitoring, PROMPT, and basic neonatal life support				
	Description	Progress	Evidence	Status

<table>
<tr><td>Safety Action 9</td><td>CAN YOU DEMONSTRATE THAT THERE IS CLEAR OVERSIGHT IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL, SAFETY AND QUALITY ISSUES?</td><td>The expectation of the Trust Board is that discussions regarding safety intelligence are continuing to take place monthly.

Analysis of the Perinatal Quality Surveillance (PQSO) continues monthly and is detailed in appendix 1. The Board Safety Champions are also supporting the perinatal leadership team to better understand and local cultures, including identifying. and escalating safety and quality concerns and offering relevant support where required</td><td>Appendix 2</td><td>Validated</td></tr>
<tr><td colspan="5">The Safety Champions meeting is chaired by the Chief Nurse and attended by the Board Non-Executive Director (NED). This meeting has a formal agenda and terms of reference and review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys and listening events, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback are standing agenda items. The service also confirms that Board Safety Champion(s) meet with the Perinatal leadership team at a minimum of bi-monthly. and that any support required of the Trust Board has been identified and is being implemented.</td></tr>
<tr><td>Safety Action 10</td><td>Description</td><td>Progress</td><td>Evidence</td><td>Status</td></tr>
<tr><td></td><td>HAVE YOU REPORTED 100% OF QUALIFYING CASES TO MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (MNSI) PROGRAMME AND TO NHS RESOLUTION'S EARLY NOTIFICATION (EN) SCHEME FROM 8 DECEMBER 2023 TO 30 NOVEMBER 2024?</td><td>The service confirms that it has reported all qualifying cases to MNSI reporting 100% compliance to the standard. It also confirms that it complies with Regulation 20 of the Health and Social Care Act 2008 in relation to appropriate and timely Duty of Candour (DOC). Standard 10 cannot be signed off until after the 30 November 2024 following the end of the reporting period.

<table><tr><td>Timeframe</td><td>New MNSI referrals</td></tr><tr><td>Quarter Two 2024-2025</td><td>2</td></tr><tr><td>Quarter Three 2024-2025.</td><td>0 (as of November 2024)</td></tr></table></td><td>Appendix 1 Table 8</td><td>On Track</td></tr>
<tr><td colspan="5">A quarterly report is collated on AMAT to confirm that all qualifying cases have been report in line with MIS year 6.</td></tr>
</table>

THE PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

Maternity staffing metrics are displayed on the perinatal quality surveillance table (PQST) each month which is submitted to the Safety and Quality Committee for oversight which is also presented to the Board of Directors. The statistical process control (SPC) charts detailed in the Board supplementary information pack, provides a data platform for interpreting the statistical significance of data points each month. It also includes regional or national comparator data where this is available. Development of this dashboard will continue. (Appendix 2)

CLINICAL SAFETY INDICATORS

STILLBIRTH

The stillbirth rate in England was updated in October 2024 (MBRRACE) to 3.9 per 1000 births. The government ambition to achieve a 50% reduction in the stillbirth rate by 2025, compared to the 2010 rate continues to be the target aspiration. This equates to a rate of 2.6 stillbirths per 1,000 births.

To understand local performance, the stillbirth rate continues to be monitored monthly by the service. The current still birth rate is 2.8 per 1000 births.

In September 2024 there were no stillbirths and October 2024 there was one associated with a twin pregnancy that underwent feticide at a tertiary fetal medicine centre at 32+6 weeks.

NEONATAL DEATH

In the month of October 2024 there was one neonatal death within 7 days. This case was a preterm baby at 22+5 weeks gestion with a maternal sepsis and abnormal CTG, who was transferred from a local level 2 unit for level 3 neonatal care. Due to the extreme prematurity the baby sadly died shortly after birth.

BOOKING BY 9+6 and 12+6

Booking compliance has continued to meet the target defined by the antenatal and newborn key performance indicators consistently in 2024. In October 2024 60.2% women were booked by 9+6 weeks gestation and 93.7% were booked by 12+6 weeks. The early bird sessions continue to be rolled out using a phased approach with a whole service trajectory plan. This change in practice was possible, utilising the Birth rate plus (BR+) funding to increase maternity support establishments across the service and has been received positively by service users and staff.

THIRD- AND FOUR-DEGREE TEAR

The Statistical control process dashboard indicates that the incidence of third- and fourth-degree tears is demonstrating early signs of improved performance. There has been a 5-point reduction since May 2024 with the lowest recorded incidence rate in the month of October 2024 of 0.5%. This is attributed to focused midwifery and obstetric leadership and dedicated multi-professional training. A monthly look back exercise is also ongoing to review the previous months perineal tears to identify themes and trends for associated learning. This is jointly led by the lead midwife and obstetrician. The latest training compliance rates are detailed in table 2.

Table 2 OASI and APPEAL training figures by staff group.

		OASI												APPEAL				
	Form of Training	Obstetricians				Midwives				STs/Fys				Midwives				
		total #s needing training	# actually trained	# booked on trainng	% trained	total #s needing training	# actually trained	# booked on trainng	% trained	total #s needing training	# actually trained	# booked on trainng	% trained	APPEAL TTT (number completed)	APPEAL TTT (number booked)	other staff trained	other staff booked on training	% trained
LTHTR	Presentation	13	13		100%	212	211		99.50%	27	29		93%	9	0	192		90.56%
	Simulation	13	13		100%	212	198		93.30%	26	29		90.00%					
Future training dates																		

SAFE STAFFING INDICATORS

The fill rates for Registered Midwives (RM) (94%-day, 92% night) and Maternity Support Workers (MSW) (77% day and 96% night) in October 2024 demonstrate an improving position overall, which is synonymous with the reduction in established midwifery vacancies. Several areas have seen increased sickness absence which has affected fill rates in month and resulted in an increase in bank and agency spend associated with Delivery Suite, Maternity A and B and maternity assessment suite.

To maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts. The implementation of strengthened approval and oversight processes for bank and agency approval has been developed and agreed to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care.

The vacancy is currently 5.9 WTE. Recruitment to the vacancy has been delayed by actions taken to support the Trust financial recovery plan, however the midwifery posts are now out to advert. The service has been contacted by several qualified midwives, seeking employment, which is a positive sign that there is the available workforce to fill the vacancies.

RED FLAGS

The incidence of maternity red flags continues to be monitored. In addition, the red flags are added to the associated risks on the register for additional oversight by the Division. The service reported 307 maternity red flag Datix incidents in the month of September 2024 and 178 in the month of October 2024. The breakdown by category is provided in appendix 4.

The highest number of red flags for both September and October 2024 were reported in the category of delays in review in the maternity assessment suite (MAS). In September 2024, there were 75 red flag incidents reporting a wait of more than fifteen minutes for review by a midwife following presentation to MAS and 42 reported in October 2024. In addition, in September 2024, 56 incidents to report a wait time of more than thirty minutes for review by an obstetrician following presentation to MAS were submitted and 41 incidents were reported in this category in October 2024.

Whilst the red flags are acknowledged, in September 2024, 96.6% of women attending MAS were seen within the NICE recommended time frame of 30 minutes and 91.9% within 15 minutes of arrival in the department. In October 2024, 98% of women were assessed by a midwife within 30 minutes of arrival and 95% within 15 minutes of arrival. none of the incidents were known to be associated with patient harm. All incidents have been linked to the active risk on the risk register and there is an ongoing service development action plan pertaining to MAS to oversee the service. The update in relation to triage is included later in the report.

PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

CARE QUALITY COMMISION (CQC)

Since the CQC report in 2023 there are several longer-term should do actions that are in progress related to induction of labour and maternity triage. The updated position is included in the table 3 below.

Table 3 CQC ongoing actions

Must/Should Do	Action	Update	Delivery Date
The service **should** ensure they monitor delays in the induction of labour process and all reasons for the delays are documented.	Recommended uplift in staffing in line with Birthrate Plus presented to Trust Board and ICB for approval of maternity staffing uplift	Phase 2 of BR+ has been approved by Board for consideration in the next financial planning round. The addition of 6.68 WTE will be used to strengthen the induction of labour pathway.	31. 03. 2025
		A working party to track performance is also ongoing to include a live monitoring process is now in place.	31.12.2025
The service **should** improve the culture where staff feel listened to.	RCOG Each Baby Counts escalation toolkit Improvement Project to be implemented across service	Each Baby Counts project ongoing behaviour workshops and Leadership days ongoing.	31.03.2025
	Listening events for all speciality groups arranged facilitated by the organisational development team.	Listening events Completed and leadership days ongoing and the SCORE survey actions are ongoing.	31.03.2025
The service **should** ensure the maternity assessment service has the right number of qualified staff and the triage telephone line is answered and monitored by a trained midwife.	Implement new telecommunications software to support management of calls coming through triage and the ability to monitor dropped calls	Although there is a system in place to alert a missed call and initiate a call back a long-term solution has been agreed. Call centre system group in place with approximate implementation of electronic call tracking within 6 weeks.	31.01.2025
	Recommended uplift in triage staffing as assessed by Birthrate Plus presented to Trust Board and ICB for approval of maternity staffing uplift. This will enable	Phase 2 of BR+ has been approved by Board and will be included in the next financial planning round. The addition of 6.68 WTE will be used to strengthen the induction of labour and triage pathways.	31. 03. 2025

	telephone triage to be separated from clinical area as recommended by BSOTS. Area for relocation has already been identified.		
	Business case being compiled to uplift obstetric staffing so that appropriate obstetric review can be achieved in the correct timeframes.	2 tier obstetric rota required. Rota cover for 9-5 in place week days.	31. 03. 2025

NHS RESOULTION EARLY NOTIFCATION REVIEW COMPLETED

On the 20 November 2024 NHS Resolution wrote to the Trust to confirm that the thematic review of cases reported by the Trust to the Early Notification (EN) scheme between 1st April 2017 and 29th February 2024 is now complete. In the letter, it was confirmed that they were satisfied with the detailed evidence of learning and completed actions provided by the service. They also acknowledged the significant continuous improvement work that had taken place since 2017 in response to the 11 themes identified by the review. They also confirmed that they were assured that appropriate actions for learning were identified at the point of the patient safety event occurring, and the actions have since been fully implemented. (Appendix 5)

WORKFORCE

The service continues to seek responsive solutions to recruitment of midwives. Table 4 details the ongoing actions. The 2023/24 workforce action plan is now completed, and actions associated with BR+ are included in the new people culture and workforce plan. This will be shared in future iterations of this report.

Table 4 Responsive recruitment and retention initiatives

Workforce recruitment and retention initiatives	Narrative
Trim training to support staff wellbeing completed by all PMS's SOP and process in development	26 colleagues trained as trauma informed practitioners who can support colleagues who have been involved in a difficult maternity or neonatal case. Sign posting to psychology or self-help included in offer and assessment.
Conversion of regular agency workers contracts to bank	5 colleagues recruited in November 2024. This will reduce the agency spend and provide stability to the service.
Student Midwife Engagement Day	Regular diarised engagement sessions planned throughout the year to promote LTHTR maternity services as a future employer.
Student Midwife Learner sessions (2 per year)	Additional sessions developed to improve learner experience with education team and midwifery leaders. Bespoke sessions planned for all learners in years 1-3.
Recruitment advert now published	The recruitment advert has now been approved for use.
LMNS workforce review ongoing to provide additional scrutiny and professional judgement on safe staffing requirements.	Review with LMNS on going using national workforce tool.

OBSTETRIC WORKFORCE

The service confirms that it is fully recruited to all consultant posts and work is ongoing to review the job plans to maximise efficiency. Currently, the consultant rota presence has increased to 88 hours per week. This is an improvement on previous months where 76.5-hour cover was provided. There is an internal review ongoing, with a business plan to provide a cost-effective middle grade rota across obstetrics and gynaecology.

CLINICAL ESCALATION

DELAYS IN INDUCTION OF LABOUR

The uptake of mutual aid during the induction of labour process is included in the Perinatal Quality Surveillance slide set. During times of high acuity, women who require induction or who are being induced but are delayed, are offered transfer to alternative providers for augmentation of labour. Whilst mutual aid is part of the Northwest clinical escalation policy and is usually facilitated within the Lancashire and South Cumbria region, the impact of transfer should not be underestimated. In September 2024 4 women transferred care at the start of the induction process because of high activity and reduced midwifery staffing. There was 2 women who were transferred in October 2024. When this occurs, the service completes a look back exercise to review the clinical outcomes of women who have transferred. In both months combined, 5 women were transferred to Lancaster Royal Infirmary and 1 to East Lancs Teaching Hospitals. From review of the BadgerNet records there were no outcomes associated with harm.

A working party to ensure that delays in induction are tracked and monitored has been commenced and this will ensure that the profile of delays are understood, and that the data can be used to shape the service and mitigate risks appropriately. Appendix 4 details performance in Quarter 2 and includes the reason for delays throughout the induction pathway as well as total numbers of delays experienced.

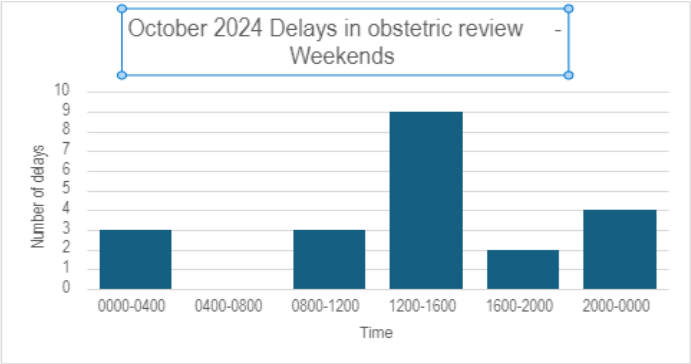
It is anticipated that going forward a monthly performance report will be shared with the maternity safety and quality committee for ongoing monitoring. In addition, updates will be included in future iterations of the report periodically so there continues to be high level understanding of the pressures on the induction service and that oversight of progress is visible to the Board of Directors.

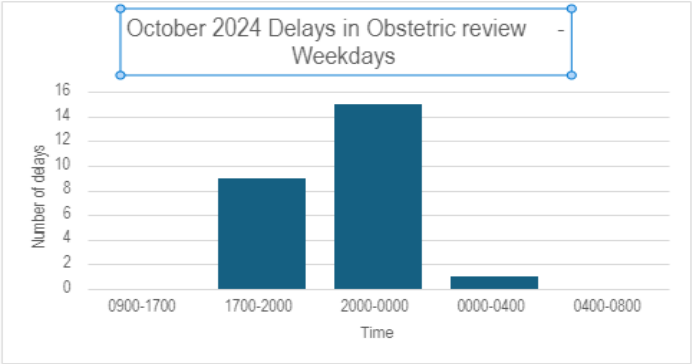
MATERNITY TRIAGE

Maternity triage continues to hold high profile in national, local and regulatory arena's due to the high risks associated with managing unplanned emergency maternity attendance. Significant investment in leadership, core staffing and the introduction of maternity support workers have stabilised and strengthened the service. To understand the profile and activity of the service, the red flag incidents are tracked, and an audit has been developed. This audit is generated monthly and will enable the service to use data to provide direction and improve safety outcomes.

In the month of October 2024, 6% of women who attended triage experienced delays in obstetric review. Table 5 provides an overview of delays by time of day both in and out of hours. Analysis of the data demonstrates that most delays occur out of hours and at weekend, when a dedicated obstetrician is not assigned to cover the service. This confirms that the action to scope a 2-tier middle grade roster is required.

Table 5 Week Day and Weekend delays by time of Day.





MIAA internal audit is undertaking a review of maternity triage to provide assurance on the provision of this service. The terms of reference have been agreed and the first part of the review is a site visit, and this is planned for December 2024

INTRAUTERINE TRANSFER (IUT) NEONATAL AND MATERNITY

The service continues to collect data related to inability to accept intrauterine transfers (IUT). To provide wider triangulation of the operational pressures on the maternity and neonatal service, the maternity specific safety and quality matrix includes a separate breakdown of all IUTs declined by maternity and those declined by the neonatal unit.

In total the number of intrauterine transfers declined by the maternity and neonatal service in September 2024 was one and one request was also declined in October 2024. In September 2024 one request was declined by NICU due to neonatal service capacity or staffing, and none were declined by the maternity service. In October 2024 one intrauterine transfer request was declined by the maternity service due to capacity or staffing and none were declined by NICU.

There was one reported incidence of NICU closure in September 2024 and October 2024, however, despite the closures in both September and October there were no reported in utero transfers of antenatal mothers from the Trust to other organisations for level three neonatal intensive care cots.

There has been a statistical reduction in the numbers of intrauterine transfers declined and this is evident in the SPC data analysis. This demonstrates a commitment by both services to accept intrauterine transfers and reflects improvement in staffing positions associated with sickness absence in the Neonatal unit and an reduction in vacant establishment in midwifery and obstetrics.

CLOSURES OR DIVERTS

In the month of October 2024 there were no maternity diverts.

WELL-LED

SINGLE DELIVERY PLAN (SIP)

Progress against the maternity and Neonatal work stream for the Trust single delivery plan is ongoing. Workstreams are aligned to national priorities associated with the three-year single delivery plan, the implementation of the maternal medicine network, improving culture, creating financial stability associated with obstetric, midwifery and neonatal staffing and achievement of the MIS safety standards. The SIP progress is overseen at a weekly meeting ensuring that actions are ongoing, and issues are escalated as required.

PERINATAL CULTURE

The SCORE survey is now complete and leadership coaching sessions are ongoing to agree the final actions arising. The local action plan will be added to the divisional people plan and is anticipated to be finalised at the beginning of 2024. The update will be included in due course.

MATERNITY REVIEW PROGRESS ON THREE YEAR PLAN ACTIONS

The Three-year delivery plan for maternity and neonatal services was published on 30 March 2023 and detailed how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

There are 4 themes identified as the key areas to deliver over the next 3 years. Within each of the 4 key themes there are 3 objectives, which comprise several actions that Trusts, Integrated Care Boards (ICBs) and NHS England. Table 6 provides an overview for information.

Table 6 Three Year Delivery Plan Themes.

No.	Theme	Objectives
1.	Listening to women and families with compassion to promote safer care	• Care that is personalised • Improve equity for mothers and babies • Work with service users to improve care
2.	Supporting workforce to develop skills and provide high quality care	• Grow our workforce • Value and retain our workforce • Invest in skills
3.	Developing and sustaining a culture of safety to benefit everyone	• Develop a positive safety culture • Learning and improving • Support and oversight
4.	Meeting and improving standards and structures that underpin our national ambition	• Standards to ensure best practice • Data to inform learning • Make a better use of digital technology in maternity and neonatal services

To provide oversight of the progress against the standards, table 7 details the number of actions that are ongoing, completed or awaiting evidence by RAG rating. It is anticipated that actions will be progressed and completed over a 3-year period from 2023-2026. However, it should be acknowledged that the plan contains 112 actions, some of which will take significant time and investment time to complete. Action completion is represented as a number and percentage for oversight.

Table 7 detailed below provides a breakdown of progress against the plan and confirms using a RAG rating key.

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

No.	Theme	Objectives Summary	Position RAG Rating (112 actions overall)			
1.	Listening to women and families with compassion to promote safer care	• Care that is personalised • Improve equity for mothers and babies • Work with service users to improve care	41/62 66%	0/62	21/62 34%	0
2.	Supporting workforce to develop skills and provide high quality care	• Grow our workforce • Value and retain our workforce • Invest in skills	15/21 71%	1/21 5%	5/21 24%	0
3.	Developing and sustaining a culture of safety to benefit everyone	• Develop a positive safety culture • Learning and improving • Support and oversight	15/19 79%	1/19 5%	3/19 16%	0
4.	Meeting and improving standards and structures that underpin our national ambition	• Standards to ensure best practice • Data to inform learning • Make a better use of digital technology in maternity and neonatal services	6/10 60%	0	4/10 40%	0

CONTINUITY OF CARER (MCoC)

The service has made significant progress in recent years in establishing 3 midwifery MCoC teams. Whilst these teams have been successfully sustained, even throughout the COVID-19 pandemic, unavoidable staffing gaps have delayed implementation.

On a regular basis the safety and quality committee receive updates to confirm that the service can safely continue with the established teams but would not be able to undertake further roll out until full staffing is achieved.

This month the service received confirmation that a specific NHSE funding work stream would be available to put additional building blocks in place to plan for an enhanced continuity teams This funding should focus on developing continuity services for the lowest decile groups and women from a black or ethnic minority background. Utilisation of the funding is being scoped by the consultant midwife and plans are in development. An update will be provided in due course.

MILESTONE ACTIONS

The charity bid was recently submitted to NHS Charities Together - Innovation Funding is in the final phase and the service awaits confirmation on whether the bid was successful.

The Preston birth centre also celebrated its 10th birthday by inviting the fist baby to be born at the centre to attend the birthday party. The team arranged an open day for families and undertook tours of the birth centre throughout the day.

The ABC trial has commenced. This a nationally standardised, evidence-based approach to management of impacted fetal head at Caesarean section which will help to address unwarranted variation in pregnancy outcomes, avoiding brain injury in childbirth. The service are one of 6 providers who have been selected to undertake this important trial.

3. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report confirms the position against the workstreams set out by the CNST NHS Resolution for year 6. In November 2024, the CNST progress was validated by the local Maternity and Neonatal System LMNS and signed off against 7/10 standards. The remaining 3/10 standards are on track to meet the recommendations but cannot be signed off until the end of the reporting period which ends on the 30 November 2024.

The perinatal quality surveillance dashboard and the red flag reporting indicates pressure points related to timely review in triage. Increased monitoring and audit of the waiting times by professional and time of day, provides wider insight into the pressure points within the service.

There is an ongoing focus on understanding and interrogating the data related to induction of labour which will be reported to the safety and quality committee receive safety intelligence data to action to support the service as needed.

4. RECOMMENDATIONS

The Board of Directors is asked to:

I. Approve the Maternity and Neonatal Service Update, noting its consideration and endorsement by the Safety and Quality committee.

II. Note the CNST update report and recommendations.

III. Confirm it is satisfied a comprehensive level of check and challenge has been applied by the Board level safety champions to understand the performance and pressures affecting the maternity and neonatal service and reflect this in the committee minutes.

IV. Receive the associated action plans for information oversight and assurance

Appendix 1 CNST MIS Year 6 Information Pack Table 1 Overall position

No	Safety Action	LMNS/ICB Validated position (4.11.2024)
1.	PMRT	
2.	MSDS	
3.	Transitional Care	
4.	Clinical Workforce	
5.	Midwifery Workforce	
6.	Saving Babies Lives (version 3)	
7.	MNVP	
8.	Training Plan	
9.	Board Assurance	
10.	MNSI/Early Notification	

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

SAFETY ACTION ONE – PMRT TABLE 1

REQUIRED STANDARD (Standard A) *	Compliance score		RAG
Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	Notification	21/21	
	Surveillance	17/17	
Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	On Track	17/17	
REQUIRED STANDARD (Standard C) *			
Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	On track	Commenced within 2 months. 18/18	
		Completed within 6 months: On track.	
REQUIRED STANDARD (Standard D) *			
Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	April 2024		
	July 2024		
	October 24		

PMRT CASES TO DATE SAFETY ACTION 1 TABLE 2

ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 6 months	Actions ongoing
150075	24+5	Neonatal death	In-utero transfer from BVH for level three neonatal care.	Yes	91767	Yes	Yes	
151211/ 151097	39+3	Neonatal death	Compassionate reorientation of care following the initiation of therapeutic cooling treatment.	Yes	91936	Yes	Yes	Referred to Maternity and Newborn Safety Investigations (MNSI) for external investigation. Classed as a PSII but investigation undertaken by MNSI all cases continue to require StEIS reporting. Formal DOC provided to the family.
151421	22+6	Neonatal death	Triplet 2. Extreme prematurity.	Yes	91959/2	Yes	Yes	
154424	41+5	Neonatal death	Admitted to maternity assessment unit with reduced fetal movements, terminal bradycardia identified on admission. Category one caesarean section, baby born in poor condition. Cooling commenced but decision made to compassionately reorientate care to palliative.	Yes	92488	Yes	Yes	Classed as a PSII but investigation undertaken by MNSI all cases continue to require StEIS reporting. Formal DOC provided to the family.
154842	24+3	Antepartum stillbirth	Admitted with reduced fetal movements and Fetal death In utero diagnosed.	Yes	92519	Yes	Yes	After action review performed; to proceed with PMRT investigation.
154826	27+5	Neonatal death	Admitted with spontaneous onset of labour, placental abruption identified on admission. Vaginal breech birth with entrapment of the aftercoming head.	Yes	92532	Yes	Yes	After action review performed; to proceed with PMRT investigation.
158232	33	Antepartum stillbirth	Multiple pregnancy, twin one feticide for complex congenital anomaly at St.Mary's hospital. Admitted unwell one week after the feticide and FDIU diagnosed.	Yes	92922	Yes	Yes	After action review performed, to proceed with PMRT investigation. St Mary's hospital Manchester sharing PMRT review.
158565	26+3	Antepartum stillbirth	Baby known to have an antenatally diagnosed exomphalos. Admitted via the emergency department with abdominal pain, fetal death in utero diagnosed on admission to maternity.	Yes	93059	Yes	Yes	After action review performed, to proceed with PMRT investigation.
161087	23+6	Late fetal loss	Intrauterine transfer from Bolton for regional neurology bed following onset of seizures. Diagnosed with central pontine myelinolysis following transfer. Fetal death in-utero diagnosed 48 hours following transfer. Antenatally known to have hyperemesis and early onset fetal growth restriction and congenital anomaly suspected. Adult safeguarding involvement following transfer, assessment made of no capacity and care provided in line with best interests.	Yes	93462	Yes	Yes	After action review performed with maternity assessment unit and neurology. Concerns with care identified by Bolton and investigation ongoing by Bolton. PMRT review shared with Bolton.

168379	24	Neonatal death	Vaginal breech birth. Compassionate reorientation of care following a rapid deterioration. Postmortem scan showed Intraventricular Haemorrhage on the left side. Optimisation prior to birth with magnesium sulphate and anti-biotics not performed.	Yes	94527	Yes	Yes	After action review performed; to proceed with PMRT investigation.
PMRT ref 93827	22+4	Neonatal death	Extreme prematurity, admitted with labour and bleeding. Born at LTHTR and transferred to Royal Manchester Children's Hospital where the baby sadly died. Placental histology showed acute chorioamnionitis indicative of a maternal inflammatory response and a fetal inflammatory response.	Yes	93827	Yes	Yes	After action review performed; to proceed with PMRT investigation.
172448	26+2	Antepartum stillbirth	Multiple pregnancy. Under fetal medicine team for potential congenital fetal anomaly in pregnancy and had amniocentesis for both babies. Fetal death in-utero of twin 2 at 26 weeks and 2 days gestation. Pregnancy continued until 37+2 for benefit of twin 1.	Yes	94965	Yes	Review ongoing, deadline not yet met	After action review performed; to proceed with PMRT investigation.
170313	23+3	Neonatal death	Previous history of preterm birth. Cervical suture in this pregnancy. Suture removed at 23+3 following admission with ruptured membranes and baby went on to be born. Baby born with faint heart rate but parents declined resuscitation following prior informed counselling by the neonatal team.	Yes	94790	Yes	Yes	After action review performed; to proceed with PMRT investigation.
174623	23+6	Neonatal death	Mother involved in an accident receiving multiple serious. Baby delivered by emergency caesarean section due to placental abruption, 23 weeks and 6 days gestation. No heart rate at birth, resuscitation included adrenalin and emergency blood. Baby transferred to NICU but in the following hours remained in an unstable critical condition and died at 06:00.	Yes	95370	Yes	Review ongoing, deadline not yet met	After action review performed; to proceed with PMRT investigation.
175626	27+3	Neonatal death	Pre-labour prolonged ruptured membranes. Mother septic screened and commenced on sepsis pathway. Abnormal antenatal CTG and baby delivered by emergency caesarean section. Decision to re-orientate the baby's care to palliative on day 6.	Yes	95542	Yes	Review ongoing, deadline not yet met	After action review performed; to proceed with PMRT investigation.
176480	22+5	Neonatal death	Intrauterine transfer from Blackpool Victoria Hospital. Extreme prematurity. Pre-labour rupture of membranes.	Yes	95653	Yes	Review ongoing, deadline not yet met	After action review performed; to proceed with PMRT investigation.
178664	33+6	Neonatal death	Out of hospital cardiac arrest at 27 days postnatal. Born at 33+6/40 and discharged from NICU at 37+5 weeks corrected gestation. Sudden Unexplained Death in Childhood process initiated alongside the Perinatal Mortality Review Tool review process and home office postmortem examination being undertaken.	Yes	95951	Yes	Review ongoing, deadline not yet met	Maternity service attended the joint after action review along with colleagues from the emergency department.

Version	Date
V1	24.10.2024
V2	28.10.2024

PMRT ACTION PLAN SAFETY ACTION 1– DATIX 151097, PMRT 91936 TABLE 3

Action Plan: ND, MNSI MI-036837 Datix 151097

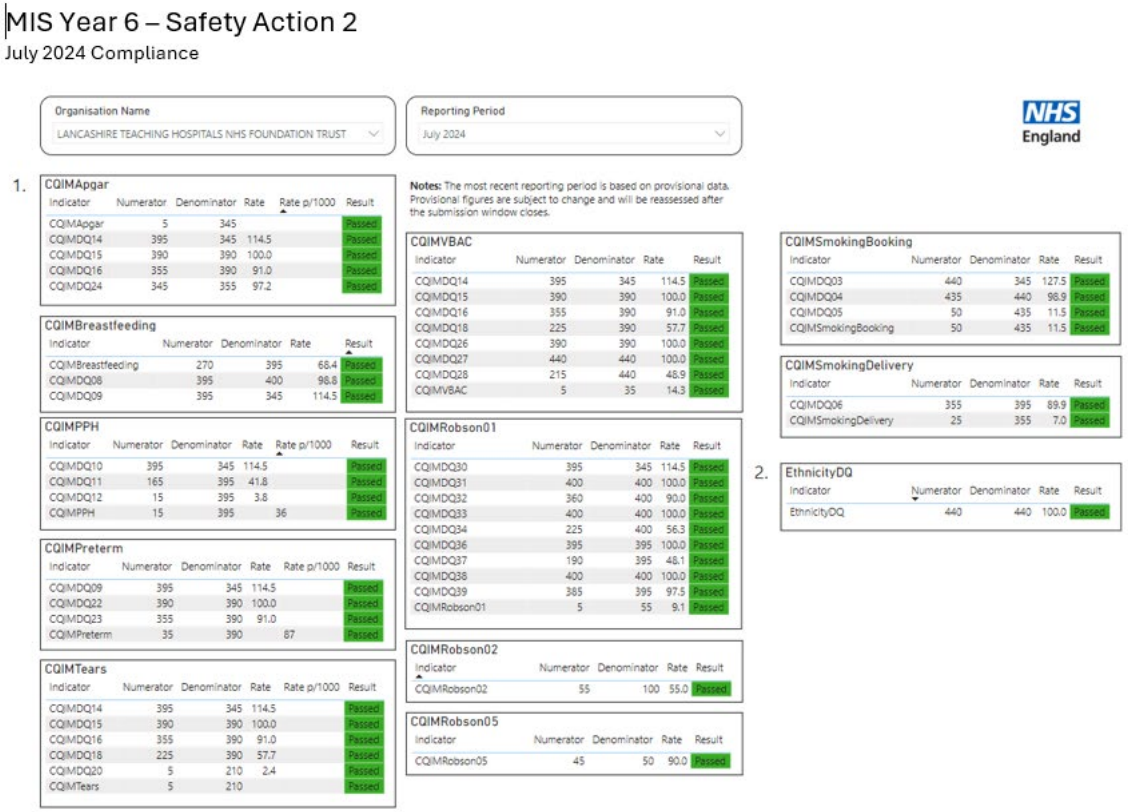
Organisation:	LTHTR
Lead Officer:	Jo Buxton
Position:	Divisional Clinical Governance and Risk Management Midwife
Tel:	01772 522711
Email:	Joanne.buxton@lthtr.nhs.uk
Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status (1 2 3 4)
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to MNSI	Clinical governance and risk management midwife	19.02.2024	Complete. MNSI investigation number MI-036837	
		StEIS report	Clinical governance and risk management midwife	21.02.2024	Complete.	
		Formal duty of candour	Clinical governance and risk management midwife	19.02.2024	Complete – Formal Duty of Candour with MNSI information provided and consent for referral to MNSI gained from the family.	
2	**MNSI safety recommendation:** The Trust to ensure that all clinicians use the local assessment tool when reviewing CTG trace and to document findings of their independent systematic review.	Audit of CTG reviews for assurance of the use of the local assessment tool and documentation of findings.	Fetal Monitoring Lead Midwife	30.09.2024	Action complete. Monthly audits continue to provide on-going assurance.	

3	**MNSI finding:** On the maternity triage the management plan about the intrapartum care setting was unclear to the parents and this left the mother feeling anxious.	Inclusion of choice and personalisation session to be included on the Saving Babies Lives (SBL) mandatory study day in-line with Ockenden recommendations.	Consultant Midwife	30.04.2024	Complete. Included within the agenda of the monthly SBL study day since 4th March 2024.	
5	**MNSI finding:** Two of the four doses of adrenaline given to the baby as part of the resuscitation were not in-line with national guidance.	Alignment of local neonatal adrenaline guidance with national guidance.	Consultant neonatologist governance lead	30.11.2024	Guideline updated. Ratification and upload to Heritage awaited.	
6	**MNSI finding:** In-line with local guidance the baby's temperature was required to be monitored at 30-minute intervals. The baby's temperature was measured at approx. two to three hours interval and ranged from 36.1. to 36.5 degrees. This meant the baby's temperature was not kept at the optimum range advocated in local and national guidance.	Learning from the incident to be communicated to staff via the Neonatal learning bulletin.	Neonatal Practice Educator	30.11.2024	Complete. MNSI report and findings shared with the Neonatal team for learning bulletin to be shared and this has been included in the Neonatal lessons of the week.	
7	**MNSI finding:** The clinicians were prepared to start active cooling treatment once the baby's condition stabilised. This meant that the range of the baby's temperature was between 36.1 and 36.5 degrees from 06:20 to 15:00 hours. Ongoing effort is required to ensure babies temperatures are maintained, in line with guidance, regardless of whether they will later require cooling treatment.	Learning from the incident to be communicated to staff via the Neonatal learning bulletin.	Neonatal Practice Educator	30.11.2024	Complete. MNSI report and findings shared with the Neonatal team for learning bulletin to be shared and this has been included in the Neonatal lessons of the week.	

SAFETY ACTION 2 MSDS TABLE 4



MIS Year 6 – Safety Action 2

July 2024 Compliance

Organisation Name: LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Reporting Period: July 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	345			Passed
CQIMDQ14	395	345	114.5		Passed
CQIMDQ15	390	390	100.0		Passed
CQIMDQ16	355	390	91.0		Passed
CQIMDQ24	345	355	97.2		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	270	395	68.4	Passed
CQIMDQ08	395	400	98.8	Passed
CQIMDQ09	395	345	114.5	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	395	345	114.5		Passed
CQIMDQ11	165	395	41.8		Passed
CQIMDQ12	15	395	3.8		Passed
CQIMPPH	15	395		36	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	395	345	114.5		Passed
CQIMDQ22	390	390	100.0		Passed
CQIMDQ23	355	390	91.0		Passed
CQIMPreterm	35	390		87	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	395	345	114.5		Passed
CQIMDQ15	390	390	100.0		Passed
CQIMDQ16	355	390	91.0		Passed
CQIMDQ18	225	390	57.7		Passed
CQIMDQ20	5	210	2.4		Passed
CQIMTears	5	210			Passed

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	395	345	114.5	Passed
CQIMDQ15	390	390	100.0	Passed
CQIMDQ16	355	390	91.0	Passed
CQIMDQ18	225	390	57.7	Passed
CQIMDQ26	390	390	100.0	Passed
CQIMDQ27	440	440	100.0	Passed
CQIMDQ28	215	440	48.9	Passed
CQIMVBAC	5	35	14.3	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	395	345	114.5	Passed
CQIMDQ31	400	400	100.0	Passed
CQIMDQ32	360	400	90.0	Passed
CQIMDQ33	400	400	100.0	Passed
CQIMDQ34	225	400	56.3	Passed
CQIMDQ36	395	395	100.0	Passed
CQIMDQ37	190	395	48.1	Passed
CQIMDQ38	400	400	100.0	Passed
CQIMDQ39	385	395	97.5	Passed
CQIMRobson01	5	55	9.1	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	55	100	55.0	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	45	50	90.0	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	440	345	127.5	Passed
CQIMDQ04	435	440	98.9	Passed
CQIMDQ05	50	435	11.5	Passed
CQIMSmokingBooking	50	435	11.5	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	355	395	89.9	Passed
CQIMSmokingDelivery	25	355	7.0	Passed

2.

EthnicityDQ

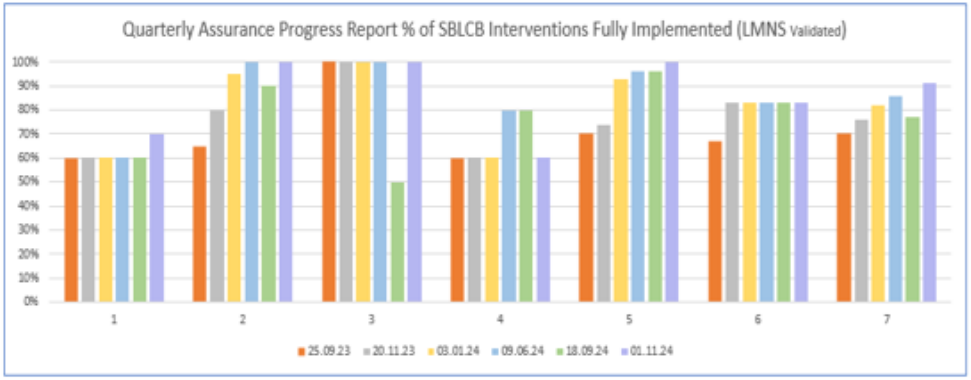
Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	440	440	100.0	Passed

Safety Action 6: Saving Babies Lives

NHS
Lancashire and South Cumbria
Integrated Care Board

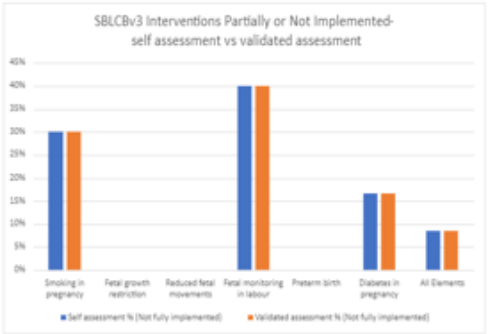
Trust Lancashire Teaching Hospital NHS Foundation Trust
ICB Lancashire and South Cumbria Integrated Care Board

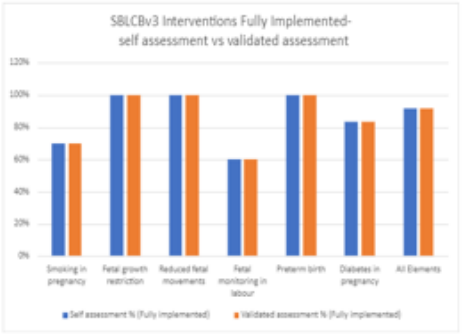
	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5					
Review Quarter	Q1/2	Q2	Q3	Pelim	Q1	Q2					
Date	25.09.23	20.11.23	03.01.24	09.06.24	18.9.24	1.11.24					
Element 1	60%	60%	60%	60%	60%	70%					
Element 2	65%	80%	95%	100%	90%	100%					
Element 3	100%	100%	100%	100%	50%	100%					
Element 4	60%	60%	60%	80%	80%	60%					
Element 5	70%	74%	93%	96%	96%	100%					
Element 6	67%	83%	83%	83%	83%	83%					
Total	70%	76%	82%	86%	77%	91%					



Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially Implemented	70%	Partially Implemented	70%	CNST Met
Element 2	Fetal growth restriction	Fully Implemented	100%	Fully Implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully Implemented	100%	Fully Implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially Implemented	60%	Partially Implemented	60%	CNST Met
Element 5	Preterm birth	Fully Implemented	100%	Fully Implemented	100%	CNST Met
Element 6	Diabetes	Partially Implemented	83%	Partially Implemented	83%	CNST Met
All Elements	TOTAL	Partially Implemented	91%	Partially Implemented	91%	CNST Met





MNVP Work within Trust

Alongside several LMNS Multidisciplinary team meetings inclusive of monthly board, We are now also in attendance to promote service user voice within the following meetings:

- Maternity Safety and Quality
- Neonatal Safety and Quality
- Safety Champions
- Request to attend PMRT with the view of ensuring advocacy through the bereavement midwifes

Project work involvement:

- Race & Health Observatory – assisting with gathering those engagement from those from minority ethnic backgrounds who have suffered post-partum haemorrhages to take part.
- Attendance and feedback for the trial of the Early bird sessions March onward 2024 - booking session for early pregnancy from 6-8weeks – now a permanent session and expanding.
- Reproductive Trauma Service – established prior to being in post.
- Maternal medicine – new service 2024
- Continuity of Carer Work – ongoing
- Choice and Personalisation work - ongoing

Regular engagements within trust for:

- Walk the Patch
- 15 Steps to Maternity and Neonatal
- Clinic Engagements sessions
- Neonatal unit Visits
- Events – Chorley Birth Centre Summer Fayre
  - Preston Birth Centre 10th Anniversary
  - Opening of the renovated EPAU unit

Trust services which the MNVP are regularly in contact with for updates and support:

- Safeguarding team (ESMET)
- Maternal Medicine team
- Bereavement Midwives team
- Digital team
- Perinatal Mental Health team
- Community Midwives team
- Neonatal team
- Infant Feeding team
- Reproductive trauma team
- Patient Experience team
- Pelvic Health team
- Early Pregnancy Support

Service user feedback requested for the following work:

- Infant feeding work to develop trust information and videos for website
- Stories taken from service users to share on trust website to celebrate and promote World breastfeeding day
- Iron deficiency anaemia in pregnancy leaflet
- Maternal Medicine New LeAPH clinic information leaflet
- Maternal Medicine Pre-Eclampsia Leaflet
- Maternal Medicine Diabetes in pregnancy support
- New Post Partum Haemorrhage (PPH) Leaflet
- Personalised Care and Support Planning Leaflet
- Pre Term Labour and Birth – update of leaflet

Conference and Training attendance:

- MBBRACE report conference 2024
- Advanced Communication and Personal Care training
- SANDS PMRT Review session
- SANDS Training
- Trust Safeguarding training and update

SAFETY ACTION EIGHT TABLE 7

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**99%** *198 compliant out of 199*	**100%** *12 compliant out of 12*	**100%** *20 compliant out of 20*	**99%** (Increase 1%) *230 compliant out of 231*
Fetal Monitoring training Attendance at full day fetal monitoring training	**97%** *190 compliant out of 195*	**100%** *12 compliant out of 12*	**95%** *19 compliant out of 20*	**97%** (Increase 1%) *221 compliant out of 227*
GAP/GROW	**98%** *195 out of 199*	**100%** *12 out of 12*	**95%** *19 out of 20*	**98%** (Increase 4%) *226 compliant out of 231*
Human Factors (attended PROMPT)	**100%** *199 out of 199*	**92%** *11 out of 12*	**89%** *24 out of 27*	**98%** (Increase 2%) *234 compliant out of 238*

	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETIST CONSULTANTS	ANAESTHETIST ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	**100%** *199 out of 199*	**92%** 11 out of 12	**89%** 24 out of 27	**92%** 11 out of 12	**86%** 12 out of 14	**92%** 48 out of 52	**96%** (Increase 1%) *303 compliant out of 316*
Pool Evacuation Not part of MIS requirements	**100%** *199 out of 199*	**92%** *11 out of 12*	**89%** *24 out of 27*	**100%** 12 out of 12	**78%** 11 out of 14	**92%** 48 out of 52	**97%** (Increase 3%) 305 out of 316

SAFETY ACTION 8 NEONATAL TRAINING COMPLIANCE

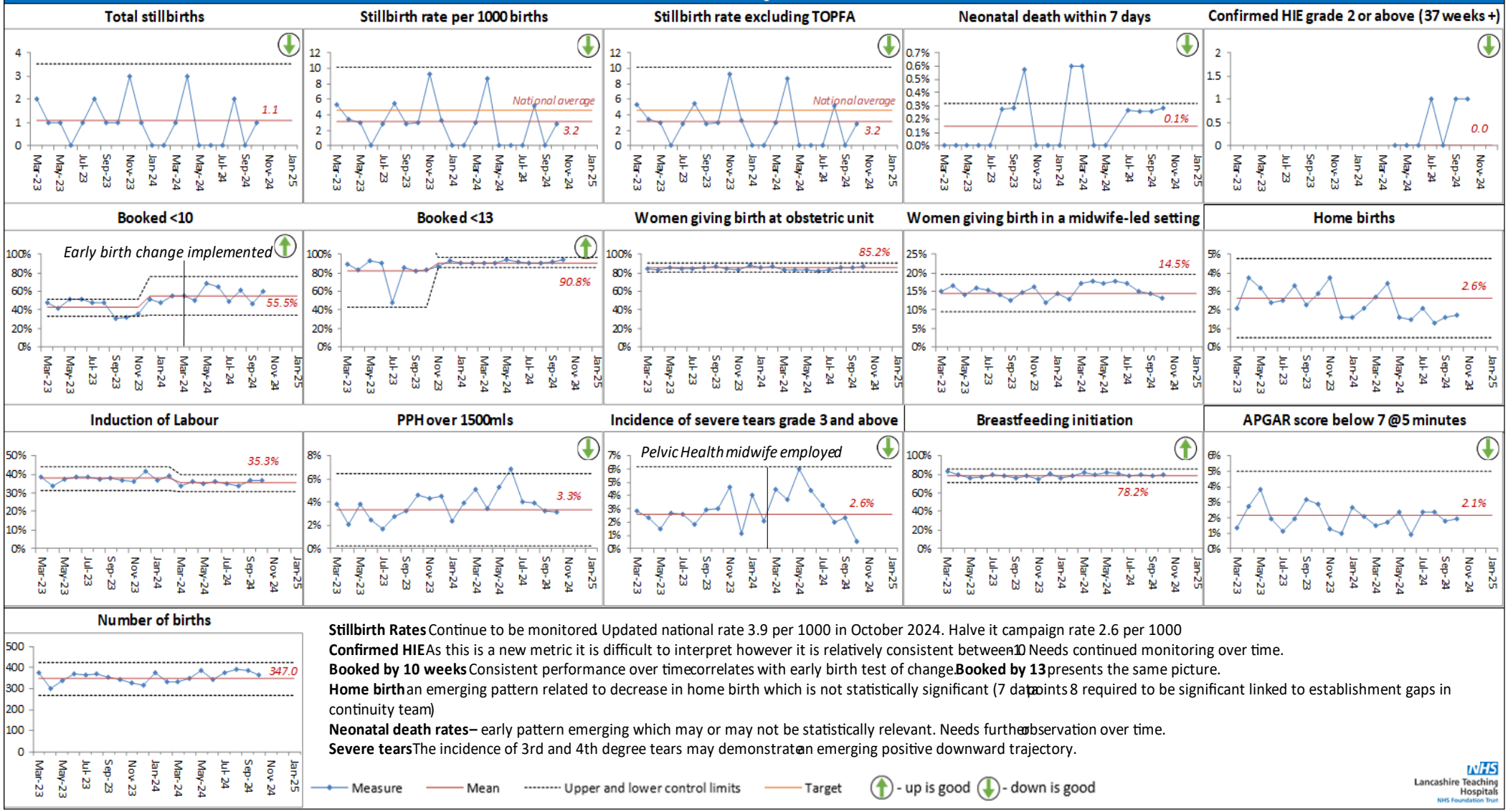
	NICU Nurses	NICU nursery nurses	CONSULTANTS	ANNP's	JUNIOR DOCTORS below ST5	JUNIOR DOCTORs ST5 and above	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	**91%** *84 compliant out of 92*	**100%** *5 compliant out of 5*	**100%** *9 compliant out of 9*	**100 %** *6 compliant out of 6*	**100 %** *10 compliant out of 10*	**100%** *6 compliant out of 6*	**94 %** *120 compliant out of 128*
NLS certification medical staff.			**100 %** *9 compliant out of 9*	**100 %** *6 compliant out of 6*	*Training not required*	**100%** *6 compliant out of 6*	**100%** *26 compliant out of 26*

SAFETY ACTION MNSI CASES TEN TABLE 8

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of MNSI investigation	Final MNSI report sent to legal team.	Duty of Candour.
36750	The mother attended the maternity assessment suite with reduced fetal movements and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and a decision was made for category one caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed moderate HIE.	Yes	Yes	Investigation complete.	Yes	Yes
36837	The mother attended the maternity assessment suite with reduced fetal movements for 24 hours and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and the mother was transferred to the delivery suite for intrapartum care. Following transfer to delivery suite the CTG deteriorated, and a decision was made for caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed moderate HIE.	Yes	Yes	Investigation complete.	Yes	Yes
36948	The mother attended the with reduced fetal movements and irregular uterine activity, the mother was due for induction of labour that day. An abnormal fetal heart rate pattern was detected on admission and the mother was transferred urgently for a category one caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated but after 24 hours a decision was made to compassionately reorientate care to palliative and the baby died shortly after.	Yes	Yes	Investigation complete.	Yes	Yes
37657	The mother attended the alongside birth centre in spontaneous labour at 41 weeks gestation. The baby was born in an unexpected poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed no indication of HIE.	Yes	Yes	Investigation ongoing	Investigation ongoing	Yes
38553	The mother underwent induction of labour at 40 weeks and 5 days gestation, gestational diabetic and previous caesarean section. Following the onset of a fetal bradycardia, the obstetric team recommended that the birth be expedited by category one caesarean section however, the mother declined consent. Following further counselling by the obstetric team the mother did later consent to caesarean section, however, declined general anaesthetic. The baby was born by caesarean section under spinal anaesthetic, a uterine rupture was diagnosed on opening and the baby was in the abdomen. The baby was passed to the waiting neonatal team, resuscitated and transferred to the neonatal unit where therapeutic cooling treatment was initiated for 72 hours. The post cooling MRI scan showed no convincing features of HIE.	Yes	Yes	Investigation ongoing	Investigation ongoing	Yes

PERINATAL QUALITY SURVIELLENCE DASHBOARD
APPENDIX 2

Clinical Safety Indicators



Stillbirth Rates Continue to be monitored. Updated national rate 3.9 per 1000 in October 2024. Halve it campaign rate 2.6 per 1000

Confirmed HIE As this is a new metric it is difficult to interpret however it is relatively consistent between 1-10. Needs continued monitoring over time.

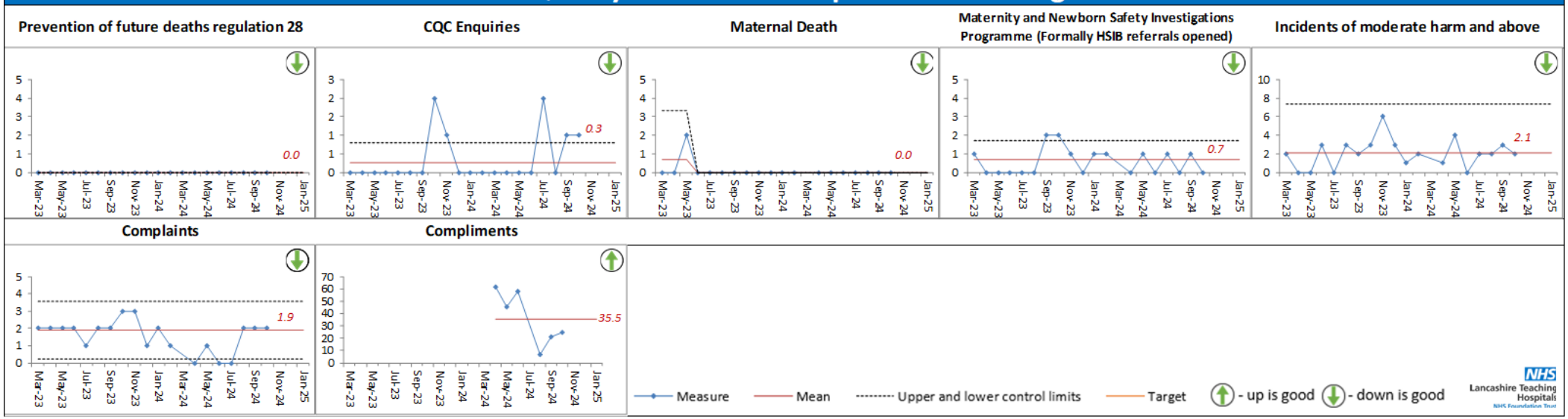
Booked by 10 weeks Consistent performance over time correlates with early birth test of change. **Booked by 13** presents the same picture.

Home birth an emerging pattern related to decrease in home birth which is not statistically significant (7 data points 8 required to be significant linked to establishment gaps in continuity team)

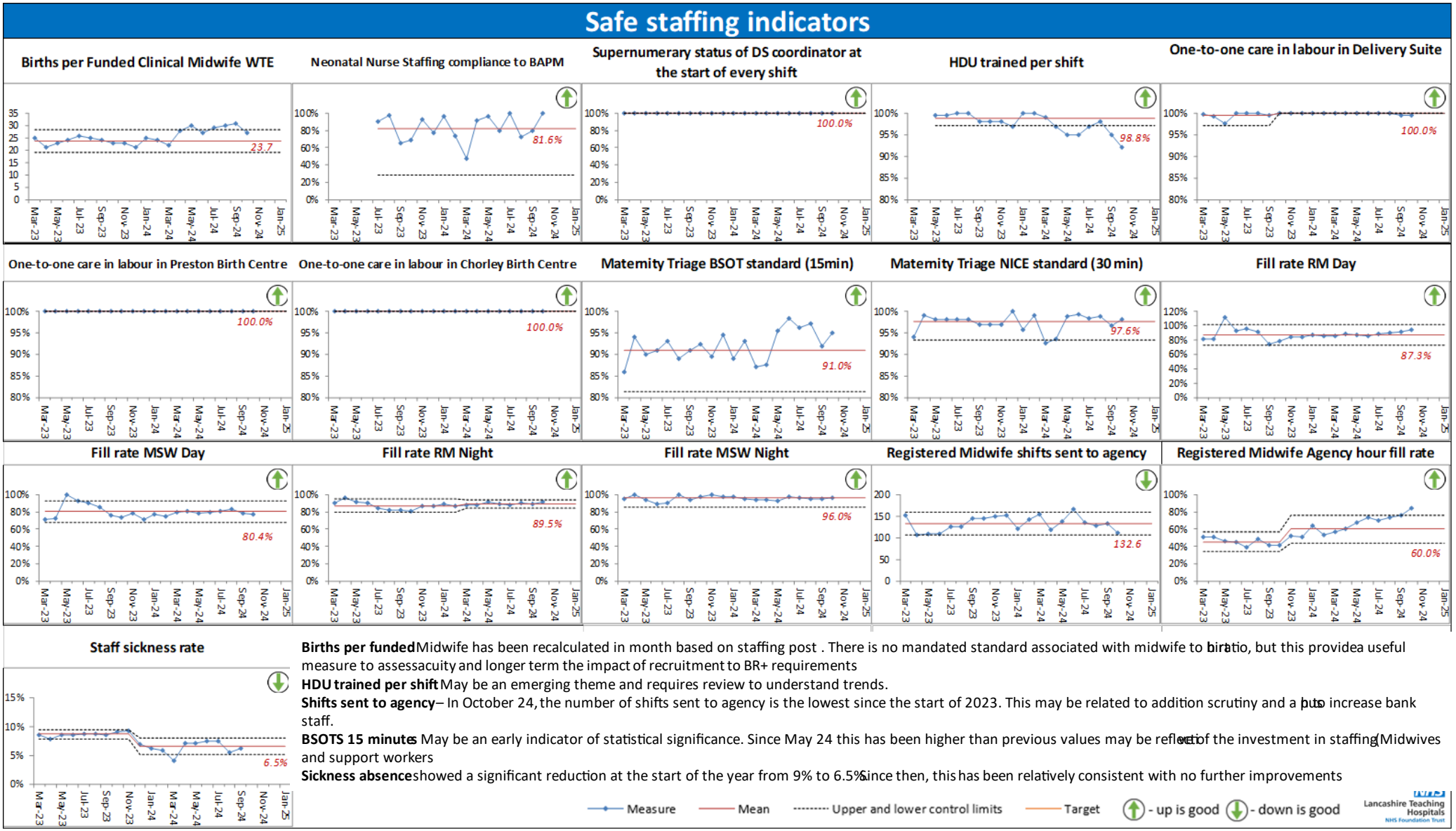
Neonatal death rates – early pattern emerging which may or may not be statistically relevant. Needs further observation over time.

Severe tears The incidence of 3rd and 4th degree tears may demonstrate an emerging positive downward trajectory.

Perinatal Quality Governance Experience and Regulation



Safe staffing indicators



Births per funded Midwife has been recalculated in month based on staffing post . There is no mandated standard associated with midwife to birth ratio, but this provide a useful measure to assess acuity and longer term the impact of recruitment to BR+ requirements

HDU trained per shift May be an emerging theme and requires review to understand trends.

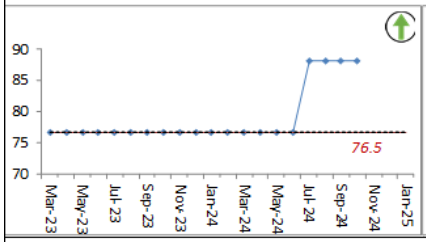
Shifts sent to agency – In October 24, the number of shifts sent to agency is the lowest since the start of 2023. This may be related to addition scrutiny and a push to increase bank staff.

BSOTS 15 minutes May be an early indicator of statistical significance. Since May 24 this has been higher than previous values may be reflective of the investment in staffing (Midwives and support workers

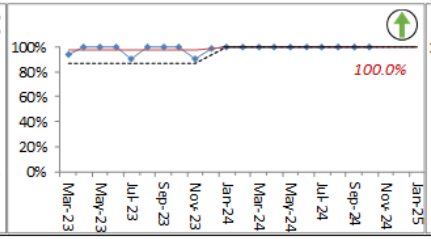
Sickness absence showed a significant reduction at the start of the year from 9% to 6.5%. Since then, this has been relatively consistent with no further improvements

Obstetric Medical Staffing

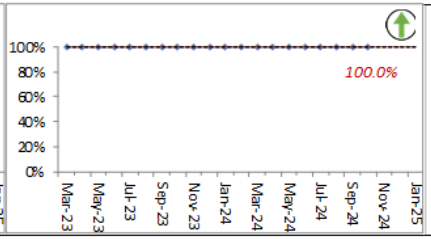
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate



Consultant hours in the obstetric unit The service continues to invest in consultant funding and the service confirms an increase in hours from 76.5 to 88 hours consultant cover.

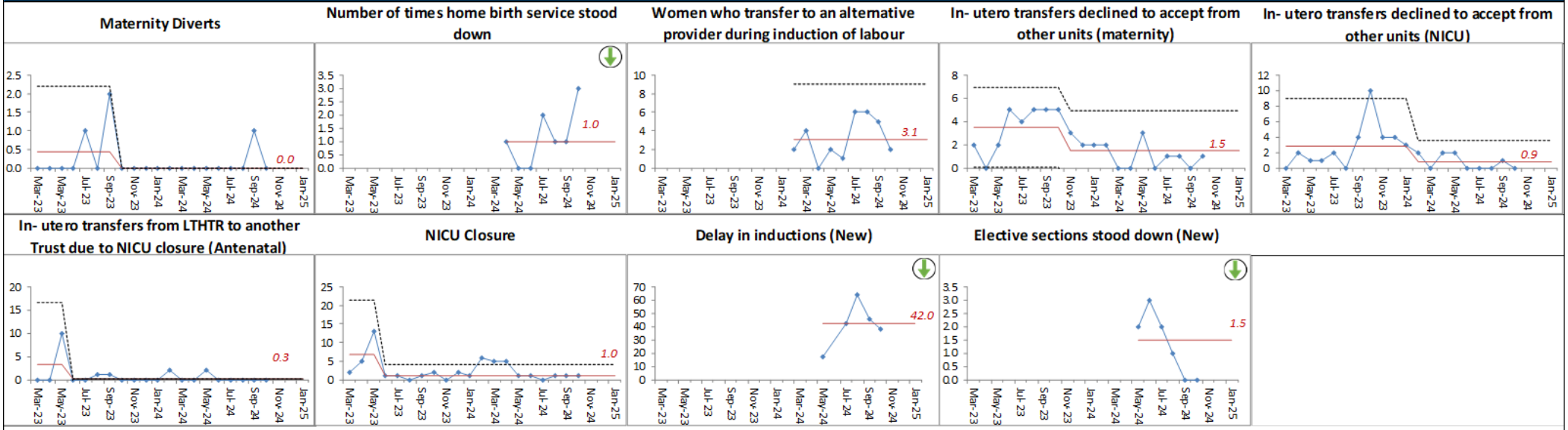
RCOG attendance remains at 100%

Consultant fill rates Consultant fill rates for acute care continues to be 100%

Measure — Mean ····· Upper and lower control limits — Target ↑ - up is good ↓ - down is good

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Clinical Escalation



The service has included new monitoring parameters to indicate pressure points in the service. This includes reporting when elective activity and mutual aid is accepted during delays in induction

In- Utero Transfers (IUT) IUT decline rates in maternity and NICU are both showing a reduction in recent months. This appears to correlate to the improvements in midwifery staffing associated with BR+ investment in 2024.

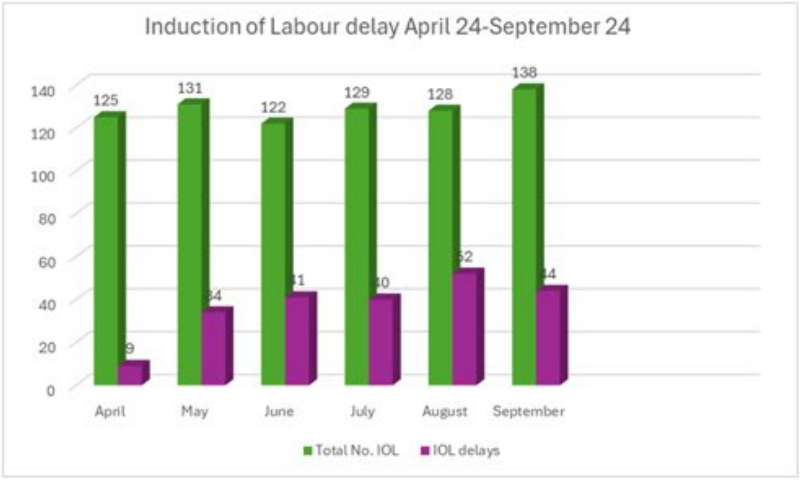
Measure — Mean ····· Upper and lower control limits — Target ↑ - up is good ↓ - down is good

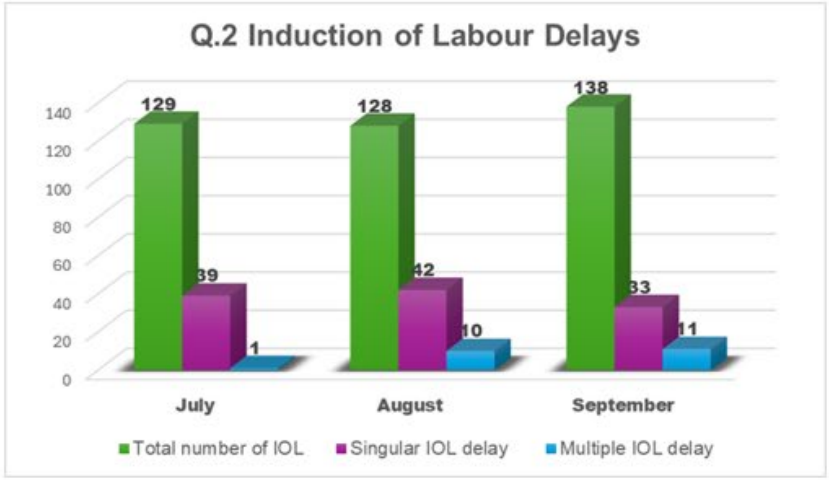
Lancashire Teaching Hospitals NHS Foundation Trust

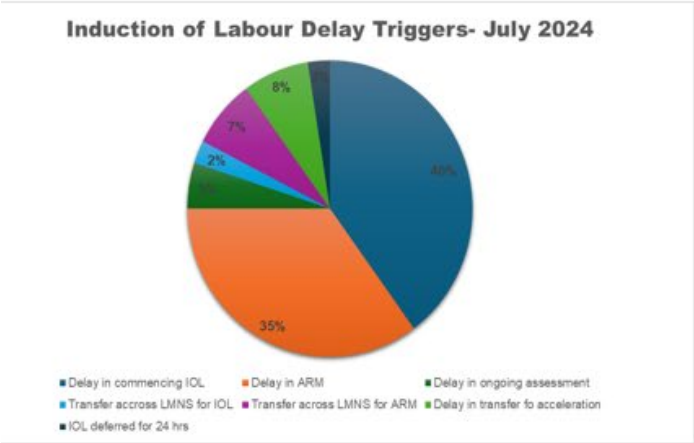
APPENDIX 3 RED FLAGS

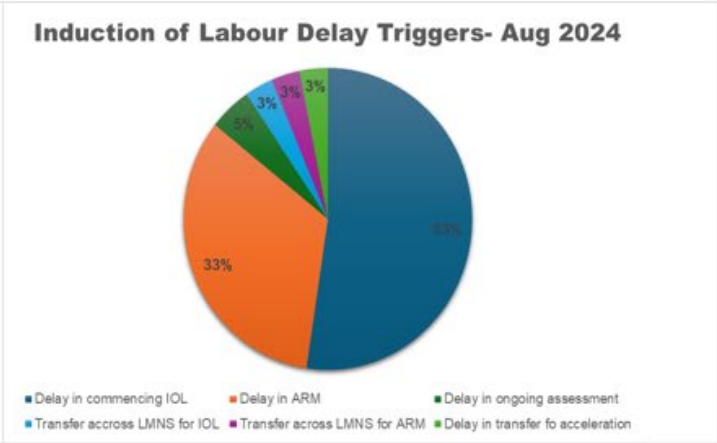
Red flag Reporting Metrics	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	Jun 24	July 24	Aug 24	Sep 24	Oct 24
Delay in time critical activity	34	38	23	10	28	51	38	16	24	36	18	41	61	40
Missed or delayed care> 60 mins in washing or suturing	0	0	0	1	1	0	1	0	2	1	2	0	0	1
Failure for women to receive the medication required.	0	0	1	0	0	0	0	0	0	3	1	0	1	0
>30-minute wait for pain relief.	3	0	1	0	1	1	0	0	4	3	3	0	2	0
Lack of full examination when woman presents in labour.	1	1	1	0	1	0	1	0	0	2	1	0	4	0
>2-hour delay in induction?	16	10	7	0	23	9	18	9	16	20	22	42	34	21
Delay in recognition of and action of abnormal signs.	0	0	4	0	1	0	1	0	2	0	1	0	1	1
Inability to provide one to one care in labour?	1	0	0	0	0	0	0	0	3	4	4	1	4	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS														
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)	21	18	13	1	12	18	29	43	38	20	46	24	75	42
>30-minute wait for obstetric triage.	25	11	10	5	9	15	12	30	31	43	47	20	56	41
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	1	0	4	1	0	0	1	2	0	0	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)	15	8	19	0	23	18	12	5	0	30	30	28	25	20
Was there a delay in transfer once labour was established? (New parameter Oct 22)	1	1	1	0	2	1	2	0	3	3	1	1	2	0
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	0	0	1	0	0	0	0	0	1	2	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	3	1	1	0	0	1	1	0	1	1	1	0	2	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)	85	14	5	0	28	38	28	95	12	13	25	5	28	4
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)				0	19	18	2	9	7	12	17	9	12	8
Total numbers of red flags	**205**	**103**	**90**	**17**	**156**	**170**	**146**	**207**	**145**	**195**	**219**	**171**	**307**	**178**

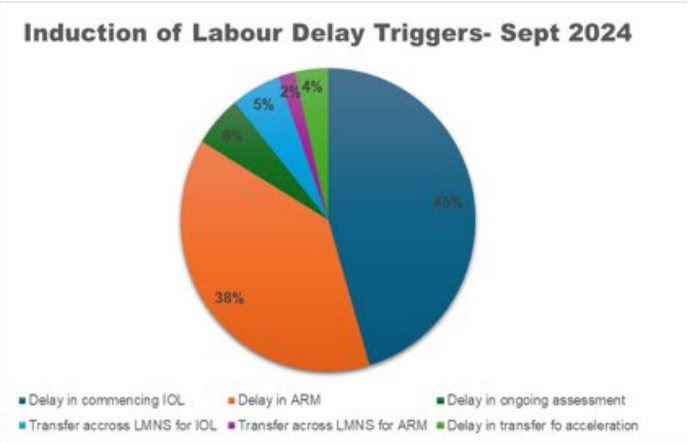
APPENDIX 4 INDUCTION OF LABOUR PERFORMANCE OCTOBER 2024.











APPENDIX 5 – NHS Resolution Final Response

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

10.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | V Crorken | 14:00

Item for assurance

REFERENCES

Only PDFs are attached

10.1 - Workforce Committee - 12 Nov 2024.pdf

Chair's Report to Board		
Chair: Victoria Crorken	**Workforce Committee**	
Date(s): 12 November 2024	**Agenda attached for information**	✓

Strategic Risks	trend	Items Recommended for approval
Being a Great Place to Work – current score 16	→	

ALERT

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

- The impact of the firebreak on resource planning and colleague morale, with an emphasis on the need to regularly communicate updates and provide clear messaging around the firebreak to address these concerns.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The findings from the MIAA audit on sickness absence, noting the substantial work being undertaken in response. A recommendation was made to review the governance structure, ensuring clear reporting pathways from operational oversight to the Workforce Committee.
- Governance and oversight challenges related to working with One LSC on people issues, particularly around visibility and engagement in decision-making processes.

ASSURE

Assurance received; Matters of positive note.

- Progress on the AHP strategy, which reflected a focused and positive approach to addressing workforce priorities.
- The "engage, retain, recognise" initiative, which highlighted ongoing efforts to support and value colleagues, fostering a positive and supportive work environment.

Workforce Committee

12 November 2024 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	V Crorken
2.	Apologies for absence	1.01pm	Verbal	Information	V Crorken
3.	Declaration of interests	1.02pm	Verbal	Information	V Crorken
4.	Minutes of the previous meeting held on 10 September 2024.	1.03pm	✓	Decision	V Crorken
5.	Matters arising and action log:	1.05pm	✓	Decision	V Crorken
6.	Strategic risk register review	1.10pm	Verbal	Assurance	V Crorken
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Assurance	K Downey
8. STRATEGY DELIVERY					
8.1	Annual Medical Employee Relation Cases	1.25pm	✓	Assurance	R O'Brien
8.2	AHP Strategy Delivery – Year 2 update	1.35pm	✓	Assurance	C Granato
9. TO BE WELL LED					
9.1	Leadership and Management Development Strategy Report	1.45pm	✓	Assurance	L Graham
10. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					
10.1	Biannual Freedom to Speak Up Report	1.55pm	✓	Assurance	L Graham
11. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
11.1	Engagement and Recognition Strategic Aim Update Report	2.05pm	✓	Assurance	L Graham
12. GOVERNANCE AND COMPLIANCE					

№	Item	Time	Encl.	Purpose	Presenter
12.1	MIAA Attendance Management Audit	2.15pm	✓	Information	R O'Brien
12.2	Guardian of Safe Working Quarterly Report	2.25pm	✓	Assurance	D Kendal
12.3	Strategic risk report	2.35pm	✓	Decision	S Regan
12.4	Reflections on the meeting	2.40pm	Verbal	Information	V Crorken
12.5	Items to alert, advise and assure the Board	2.45pm	Verbal	Information	V Crorken
13.	ITEMS FOR INFORMATION				
13.1	Exception report from the DIFs		✓	Information	
13.2	Date, time, and venue of next meeting: *14 January 2024 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	V Crorken

10.2 EDUCATION, TRAINING AND RESEARCH COMMITTEE CHAIR'S REPORT

Other | P O'Neill | 14:10

Item for assurance

REFERENCES

Only PDFs are attached

10.2 - Education Training and Research Committee 8 Oct 2024.pdf

Chair's Report to Board		
Chair: Professor Paul O'Neill	Education Training and Research Committee	
Date(s): 8 October 2024	Agendas attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
Include current score – in trend column show an arrow going up / down or static	→ 16	**None.**

ALERT

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

None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Reprioritisation of Research Studies - The Committee noted concerns from senior consultants about prioritising commercially funded studies over academic studies, potentially affecting reputation. While the Committee acknowledged the need for financial balance, the potential for reputational impact was highlighted as a matter for ongoing monitoring and consideration.
- The need for consistent quoracy across assurance committees was flagged. This would be raised with the Executives to ensure reliable committee function and maintain assurance integrity.
- The ongoing work in postgraduate medicine, especially under external agency scrutiny, remained a point of focus. The Board was advised to monitor progress as improvements were pursued.

ASSURE

Assurance received; Matters of positive note.

- The Knowledge and Library Services annual report received commendation, highlighting the exemplary work in supporting staff development and resource accessibility.
- Early-stage work on University Hospital status was underway, demonstrating strategic alignment with broader organisational goals and commitment to growth in education and research capabilities.

Education, Training and Research Committee

8 October 2024 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	P O'Neill
2.	Apologies for absence	1.01pm	Verbal	Information	P O'Neill
3.	Declaration of interests	1.02pm	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 5 September 2024	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.04pm	✓	Decision	P O'Neill
6	Strategic risk register review	1.05pm	Verbal	Assurance	P O'Neill
7.	PERFORMANCE				
7.1	Core skills training report	1.15pm	✓	Assurance	H Juwale
7.2	Quality surveillance report	1.30pm	✓	Assurance	H Juwale
7.3	Lancashire Teaching Hospital Annual Provider Self-Assessment 2024	1.45pm	✓	Decision	H Juwale
8.	STRATEGY AND PLANNING				
8.1	Research and Innovation annual report strategy update	2.00pm	✓	Assurance	P Brown
8.2	Knowledge Library Services Annual Report	2.15pm	✓	Assurance	S Corrin
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic Risk Register Review	2.30pm	✓	Decision	P O'Neill
9.2	Items to alert, assure, advise to the board or items or referral to/from other committees	2.35pm	Verbal	Information	P O'Neill
9.3	Reflections on the meeting	2.40pm	Verbal	Information	P O'Neill
10.	ITEMS FOR INFORMATION				
10.1	Feeder groups Chair's reports negative/positive escalations:			Information	H Juwale/ P Brown

№	Item	Time	Encl.	Purpose	Presenter
	a) Apprenticeships Strategy & Assurance Committee – no meeting held b) Training Compliance and Assurance Sub-committee c) Education Finance and Business Sub-Committee – no meeting held d) Research and Innovation Sub-Committee		✓ ✓		
10.2	Date, time, and venue of next meeting: 10th December 2024, 1pm via MS Teams	2.45pm	Verbal	Information	P O'Neill

11. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)

11.1 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | T Whiteside | 14:20

Item for assurance

REFERENCES

Only PDFs are attached

11.1 - Finance and Performance Committee Sept Oct 24.pdf

Chair's Report to Board		
Chair: T Watkinson	Committee: Finance and Performance	
Date(s): 24 September 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	EPRR Core Standards Annual Assurance 2024/25 – approved under delegated authority from Board

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

- **Financial Recovery Plan:** The financial recovery was identified as a high-risk area. The need to inform the Board of the current status, risks and the high-stakes nature of the financial forecast was agreed upon, with attention on the risk to delivery.
- **One LSC**: It was agreed that the Board would be alerted to the issues and risks within the One LSC system, particularly in light of ongoing collaboration challenges.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Business Planning for Next Year:** A broad discussion took place around business planning highlighting the Trust's contributions to system-wide planning and potential opportunities within that. It was agreed this would be brought to the Board's attention to ensure alignment with upcoming system changes and opportunities.

ASSURE

Assurance received; Matters of positive note.

- **Performance Progress:** Positive progress noted in the performance report, particularly in UEC improvements, with some caveats around diagnostics and outpatients' performance. Significant efforts had been made in ambulance handovers, boarding, and ED overcrowding, though 12-hour waits remained a pressure.
- **EPRR Core Standards:** Substantial assurance was achieved in the Emergency Preparedness, Resilience, and Response (EPRR) report with actions in place to address areas of partial compliance. However, concerns were raised about business continuity planning, where further expertise is required.
- **Grip and Control on Financial Forecast:** Despite the financial recovery challenges, there was reassurance that the teams had been working hard to maintain a strong grip and control over financial performance.
- **Planning Framework**: A positive update was provided on the steps being taken to improve planning controls, strengthen levels of partner, stakeholder and colleague engagements, in the formulation of the 10-year Strategic Plan and 2025/26 Operating Plans.

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 22 October 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	

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

- **Financial Recovery Plan**: The financial recovery remains as a high-risk area.
- A shift in the financial forecast had revealed a **deteriorating deficit position**, prompting the need for a comprehensive reset. This is aimed at reassessing financial strategies and implementing corrective actions to stabilise the Trust's financial outlook – including across the wider 3-year horizon. The Committee stressed the importance of maintaining an appropriate balance between financial and safety & quality risks, and has referred to Safety & Quality Committee for further scrutiny.
- **Cash**: The Trust's financial position and cash flow remained a concern, with potential cash exhaustion by early 2025 without further mitigations. Capital spending reviews were underway to seek cash support, prioritising payments in line with agreed principles.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **One LSC Transfer**: Concerns were raised regarding the adequacy of budget control mechanisms and the significant workload for HR, digital, and finance teams. The Committee stressed the need for close monitoring post transfer.
- **Single Improvement Plan:** The Committee identified gaps in tracking key milestones within the SIP. While some improvements in control structure and reporting were noted, visibility and risk concerns remained, especially in relation to the plan's organisation-wide rollout. Further efforts were requested to enhance transparency and clarity around key outcomes from the transformation programmes, to provide assurance on the path to achieving improvements in the NOF rating, CQC rating, and financial sustainability.
- **Single Tender Waivers:** Although increased focus was noted, further action was required to drive down the operational reliance on maintaining the status quo.

ASSURE

Assurance received; Matters of positive notes

- **Winter Plan** – scrutinised preparedness for winter, with acknowledgement of further work and level of risk exposure to close identified bed gaps.
- **Digital Strategy** – good progress was noted, particularly regarding license consolidation, automation benefits, and enhanced data capture processes that would support improved financial outcomes. Sought new measure onto IPR that demonstrates digital contribution and ensures effective monitoring.

Finance and Performance Committee

24 September 2024 | 09.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	09.00am	Verbal	Information	T Watkinson
2.	Apologies for absence	09.01am	Verbal	Information	T Watkinson
3.	Declaration of interests	09.02am	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 27 August 2024	09.03am	✓	Decision	T Watkinson
5.	Matters arising and action log:	09.05am	✓	Decision	T Watkinson
6.	Strategic Risk Register	09.10am	✓	Decision	S Regan
7.	STRATEGY AND PLANNING				
7.1	a) Planning Controls Update b) Winter Plan	09.20am	✓	Assurance	G Doherty
7.2	Business Planning Process 2025/26	09.45am	✓	Assurance	G Doherty
7.3	Single Improvement Plan	09.55am	✓	Assurance	A Brotherton
7.4	Financial Recovery Plan	10.05am	✓	Assurance	D Stonehouse
7.5	External Dependency Update	10.15am	✓	Information	G Doherty
	COMFORT BREAK 10.25am-10.30am				
8.	FINANCIAL PERFORMANCE				
8.1	M5 Finance Report	10.30am	✓	Assurance	D Stonehouse
8.2	Investigation & Intervention Update	10.45am	✓	Assurance	D Stonehouse
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	10.55am	✓	Assurance	K Foster-

					Greenwood
9.2	EPRR Core Standards Annual Return	11.15am	✓	Assurance	K Foster-Greenwood
10. GOVERNANCE AND COMPLIANCE					
10.1	Items to alert, advise or assure the Board.	11.25am	Verbal	Information	T Watkinson
10.2	Reflections on the meeting	11.35am	Verbal	Information	T Watkinson
11. ITEMS FOR INFORMATION					
11.1	Action plans from Divisional Improvement Forums *(Surgery, W&C, Diagnostics)*		✓		
11.2	Contract Performance		✓		
11.3	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum inc. TOR – not submitted (c) Information Governance & Records Committee. (d) Digital & Health Informatics Divisional Board – meeting stood down (e) SIB Minutes – no August meeting (f) CSESC Update		✓ ☒ ✓ ☒ ☒ ✓		
11.4	Deficit Protocol Controls Overview		✓		
11.5	Date, time and venue of next meeting: *22 October 2024 09.00am – 12.00pm, Microsoft Teams*	11.45am	Verbal	Information	T Watkinson

Finance and Performance Committee

22 October 2024 | 9.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	9.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	9.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 24 September 2024	9.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	9.05am	✓	Decision	T Whiteside
6.	Strategic Risk Register	9.10am	✓	Decision	S Regan
7.	STRATEGY AND PLANNING				
7.1	Planning Controls Update	9.20am	✓	Assurance	G Doherty
7.2	Single Improvement Plan Review	9.35am	✓	Assurance	A Brotherton
7.3	External Dependencies Update	9.50am	✓	Assurance	G Doherty
7.4	Digital Strategy 6 Month Update	10.05am	✓	Assurance	S Dobson
8.	FINANCIAL PERFORMANCE				
8.1	Month 6 Financial Position and General Financial Update	10.20am	✓	Assurance	D Stonehouse
8.2	Trading Accounts	10.40am	✓	Information	C McGourty
8.3	Lancashire Procurement Collaboration Update	10.50am	✓	Information	J Collins/ M Doyle
8.4	HFMA Checklist – Grip and Control Update	11.00am	✓	Assurance	D Stonehouse
	COMFORT BREAK 11.10am-11.15am				
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	11.15am	✓	Assurance	K Hudson
9.2	Winter Plan Update	11.30am	✓	Assurance	M Brown

№	Item	Time	Encl.	Purpose	Presenter
10. GOVERNANCE AND COMPLIANCE					
10.1	Items to Alert, Advise or Assure Board	11.40am	Verbal	Information	T Whiteside
10.2	Reflections on the meeting	11.45am	Verbal	Information	T Whiteside
11. ITEMS FOR INFORMATION					
11.1	Action Plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chair's Reports**: (a) ICS, ICP, PCB System Update (b) ELFS Management Board Minutes		✓		
11.4	Date, time, and venue of next meeting: *26 November 2024, 9am-12pm, Microsoft Teams*	11.50am	Verbal	Information	T Whiteside

11.2 INTEGRATED PERFORMANCE REPORT AS AT 31 OCTOBER 2024 INCLUDING FINANCE UPDATE AND SINGLE IMPROVEMENT PLAN

Other | Executive Team | 14:30

Item for assurance

REFERENCES

Only PDFs are attached

11.2 - Integrated Performance Report as at 31 October 2024.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report							
Report to:	Board of Directors			**Date:**	5th December 2024		
Report of:	Executive Team			**Prepared by:**	Executive Directors		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☒	**For decision**	☐		**For information**	☐	

Executive Summary:

The purpose of this report is to provide the committee with an update on the Trust's performance as at the end of October 2024, unless otherwise stated.

Operational Performance Summary

UEC: Performance against the national 4-hour access standard had shown an improving trend over the summer months however the compliance position saw a deterioration is September and further deterioration in October 2024. Performance is below the improvement trajectory set.

The Trust is below the national average of 73% and ranked 8th best performing in the NW Region. Similarly, increases have been seen against the 15-30 min and over 60-minute ambulance handover standards, boarding on wards and overcrowding within the Emergency Department. Pressures persist with patients experiencing long lengths of stay (12 hours+) within the Emergency Department and this is a key area of focus within the UEC Improvement Plan and links closely to hospital bed occupancy and the number of patients who are classified as 'No criteria to reside' (NCTR).

The number of patients within this NCTR cohort saw a decreased in October (not statistically significant change or trend) with further analysis being sought to better understand the time/days each person is spending away from their home, to allow a better understanding of the associated bed pressure.

Increases in attendance have been noted in ED attendances (all types) (+3.4% versus September) with an inpatient Length of stay (LOS) consistent with September at 8 days. This is lower than the Model Health peer value of 10 days.

Consequences of high bed occupancy has resulted in an increase in the number of patients 'boarded' in non-bed spaces from an average of 16 boarded patients in September to 26 in October. Additionally increases have been seen in the number of escalation beds occupied from 14 in September to 15 in October. Actions to mitigate this focus on improving ward and board round processes, increasing the use of Same Day Emergency Care (SDEC) facilities, improved discharge processes and mobilisation of the new AMU model of care. However, it should be noted that all improvement areas will see incremental improvements throughout the course of the financial year. As such, winter plans have been developed to further mitigate the surge demands over the forthcoming months.

Elective Recovery: September has seen a continued reduction in long waits for elective treatment with further reductions seen in the over 52 week waits 1662 (Sept 24) versus 1745 (Sept 24) this is the seventh month of reduction. The trend of reducing over 65 week RTT waits has deteriorated in October with 29 x 65 month end breaches being reported due to capacity and additional funding shortfalls. Close monitoring at patient level is ongoing to ensure any 65 week+ breaches are minimised. Prioritisation of capacity will focus on cancer, emergency and urgent clinical needs. Comparison to the latest NW region position indicates that the Trust is currently 11th out of all acute and specialist trusts and 4th out of acute Trusts in terms of the overall number of 65 week waiters with ongoing reductions each week.

A focus on productivity and reducing lost capacity via on the day cancellations and DNAs is a central part of the mitigation plans.

Cancer: 62 day compliance for October 24 is slightly below trajectory however remains an unvalidated position. Actual performance has improved compared to last month. The unvalidated Faster Diagnosis Standard (FDS) performance is 5.4% above trajectory for October. There remains a small number of tumour group areas with fragilities however improvement plans have been developed for each tumour group and are monitored closely.

Diagnostics: Performance against the Diagnostic access standard (DM01) has fallen below the trajectory for October, following a period exceeding the trajectory for 2 months. The Trust remains significantly below the national standard and review of the lasts published data indicates that LTH is the second worst performing NHS Trust in this area in the NW region. Key drivers of under performance relate to Non Obstetric Ultrasound (NOUS), endoscopy and echocardiology modalities. The Diagnostic Improvement group established with ICB partners is driving productivity, demand and transformation opportunities. Key actions to address poor performance relate to demand management, access and reducing DNAs, improved waiting list management and detailed capacity and demand analysis with corresponding work force plans being developed.

Safety and Quality

Safe Staffing requirements
Nurse and Midwifery safe staffing reporting continues on a monthly basis through the safety and quality committee. The adult inpatient areas remain in a positive position with RN staff fill rates achieving >95% fill rates, despite the current HCA vacancy rate ranging between 14-16%, bank HCA's enable the fill rates to meet the required standard. The maternity fill rate position for registered midwives (RM) achieved 96% in month which is an improved position following recruitment to the team. The maternity support worker fill rate has reduced in month to 85% due to sickness and vacancy. A plan is in place regarding recruitment.

Patient Experience and Involvement
The number of complaints per 1000 beds days continues to demonstrate a reduced rate which is positive and is as a result of increased focus on local resolution for patients and families. The focus on patient experience continues with specific focus on the Urgent and Emergency improvement plans and inpatient pathways, the national inpatient surveys have provided specific areas of focus and feedback from patients, however, we recognise that the UEC pathway in totality has a significant impact of overall experience of patients, their families and staff and therefore this is a key priority of this programme of work.

The number of compliments recorded in October rose to 668, demonstrating the motivation experienced by teams in recognising formally the multiple numerous thank you's and positive acknowledgements that they receive.

STAR accreditation
STAR accreditation standards continue to exceed the internally set target. The Star accreditation process has been refreshed to introduce the mandatory standards that mirror areas that are consistently not achieving. This was predicted to initially negatively impact the outcomes within STAR with the aim to leading to an improvement. This can be seen in this months data point drop to 85% to 82%, this reflects a deteriorated position in 3 areas. The disaggregation of the whole Trust position from that of the higher risk ward, ED and theatre areas is now included to ensure additional oversight of areas that present increased risk.

HSMR
Mortality metrics remain stable and within expected parameters.

Pressure Ulcers
The pressure ulcer data is now presented against the average number of pressure ulcers reported in the last 3 years. Pressure ulcers are considered as a proxy for the standard of care delivered and an underpinning improvement plan is aimed at minimising both the overall numbers and the category severity of pressure ulcers recognising the poor experience that occurs for patients when a pressure ulcer is acquired in hospital. This work continues.

Maternity
In November 2024, the CNST standards were validated by the local Maternity and Neonatal System LMNS and signed off against 7/10 standards. The remaining 3/10 standards are on track to meet the recommendations but cannot be signed off until the end of the reporting period which ends on the 30 November 2024.
Still birth rates are stable and within expected range. More detail is contained within the maternity neonatal report.

Boarding
The number of patients placed in spaces outside of a designated bed space, referred to as boarding, continues in response to supporting safety within the Emergency Department. It is recognised this is a symptom of the UEC system not working effectively and is a short-term measure until the system UEC plan is delivered and suitable capacity is created to meet the demand identified within the community. The average of 26 patients per day equating to 806 bed days is the October position. Feedback from staff and patients is indicating that ward moves later in the day are leading to further impact on their experiences therefore work is underway to explore an alternative approach to this referred to as continuous boarding, where an agreed number of patients are automatically moved from assessment units at agreed times of day to move flow earlier in the day and improve patient and staff experience out of hours.

Care Quality Commission
In total, the Trust has 54 recommendations in the form of Must Do's* or Should Do's** (18 Must Do's and 36 Should Do's). Some recommendations are duplicated across the different core services and upon streamlining, there are 44 recommendations in total (13 Must Do's and 31 Should Do's).

The Quality Improvement Plan is the response to these must and should dos and forms part of the single improvement plan. Progress in relation to the progression of CQC must and should do's is now being reported through the Single Improvement Plan Board chaired by the Chief Executive.

Of the 75 actions identified within the action plan, 60 actions have been delivered, (a further 10 since the last report to Safety and Quality committee) and 11 actions have been assessed as on track for delivery demonstrating a significant amount of progress to date. Five actions have been stood down as no longer applicable.

From the 18 'Must Do' recommendations, 11 have been assessed as delivered and the themes of the 7 outstanding 'Must Do' recommendations are related to training and appraisal compliance by professional group and CQC core service, medical staff training compliance in urgent and emergency care and medicine, evidence of a timely assessment by a senior decision making in surgery, medical staffing in medicine and documentation specifically in relation to fluid balance and vital signs. A delivery date has been set for each of the outstanding must do's.

From the 36 'Should Do' recommendations, 29 have been assessed as delivered and the themes of the outstanding 7 'Should Do' recommendations are related to medical staffing in ED, timely medical review when not being provided care and treatment on the correct medical speciality ward, compliance with infection, prevention and control standards in medicine, evidence of NEWS2 recording in medicine, STAR audit outcomes in ED, equipment and environment maintenance and midwifery staffing. A delivery date has been set for each of the outstanding should do's.

People and Culture

The overall sickness absence rate remained above 6% throughout Quarter 2 and this is slightly higher than the same period last year. Short term sickness has increased slightly in line with the usual seasonal cold and flu spike. It also means that we are off plan with the target of an annualised reduction of 1% by the end of the financial year.

Our winter vaccination campaign is underway and at the end of October, 20% of colleagues had accessed the flu jab, and 7.5% had received a Covid-19 booster vaccination. Our vaccinators continue to work across sites and shift patterns to make vaccines accessible, and they are particularly focusing on wards and departments with low uptake.

Musculoskeletal and mental health related absence have both steadily increased over the last 5 to 6 months, and the waiting times in our support services are directly impacting upon absence management. Recruiting to a vacant Occupational Health physiotherapist post will enable a more pro-active and timely response for colleagues with musculoskeletal conditions; however the capacity pressures within the psychological wellbeing service are a long-term risk, and an additional psychologist is required to achieve waiting list reduction.

The number of reported violence and aggression incidents has increased slightly in M7. Focused continuous improvement work around preventing and reducing incidents is underway in three test areas (Rookwood A, Rookwood B and Medical Assessment Unit Chorley), and the Big Room driving this work, are working collaboratively with the Mental Health Big Room to join up some of the areas of focus.

There has been a spike in turnover this month driven by the One LSC TUPE and transfer of associated workforce to ELHT.

Financial Sustainability

Income and Expenditure
The Trust had submitted the final plan in line with the NHSE control total, a deficit of £21.9m. In month 6 the Trust received funding to cover the deficit the Trust now has a break-even plan.

At month 7 the Trust has a deficit of £15.5m an adverse position of £8.2m against a planned deficit of £7.3m. The main variances to plan are:
- £5.4m variance to Financial Recovery Plan Target
- £2.6m shortfall on income from urgent and emergency care capacity and investment funding to support frailty and intermediate care

The Trust has operational pressures in:
- the acute medical pathways reflected in overspends in medical and nursing pay budgets
- capacity issues resulting in elective, day case and outpatient income under performance

The Trust is reviewing its forecast recognising that it is a high-risk plan with a number of efficiency schemes not yet delivering to plan, risks that have materialised since the plan was set and continued operational pressures.

Capital Position
Capital expenditure in the year to date at £20.7m is c£6.8m less than plan.

The delegated capital limit for the system has been reduced by £10m as a consequence of the system revenue plans being in deficit. The Trust has reduced the capital plan by £3.2m to contribute to the system reduction of £10m. This reduction is being worked through the Capital Planning Forum, however it should be noted that this £3.2m reduction requires the Trust to defer expenditure on backlog maintenance and equipment replacement, and as a consequence this significantly increases the risks to operational areas.

Cash Position
The Trust has received £10m of revenue support from NHSE in addition to £21m additional income. Operational pressures associated with the revenue deficit mean that despite the receipt of these sums the Trust is utilising capital cash for revenue which is contrary to DHSC guidance.

Continuing operational pressures associated with the revenue deficit are adding to the cash burden in the plan and it is expected that the Trust will require further cash support from DHSC in Q4.

Financial Recovery Plan Target
The Trust's objective to reach financial balance on a recurrent basis by the end of the three year period (2026-27) will require delivery of an ambitious and very challenging financial recovery plan. In 2024-25 a gap of £58m will need to be mitigated. Of this £8.3m will be closed through income/productivity contribution, £8.3m through system optimisation/risk and a balance of £41.4m (5%) will be delivered through core cost improvement.

In month 7 the Trust has delivered £10.3m year to date, which is 66% of the plan of £15.7m however 51% of this was non-recurrent. Annually £16.1m; (£11.5m recurrently) has been delivered towards the £58m target which is 28%.

Use of Resources
The Trust is in Segment 3.

Segment 3 is where there are significant support needs against one or more of the six national oversight themes and in actual or suspected breach of the licence.

Segment 3 means the Trust will receive mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested.

The Agency spend to month 7 was £6.9m, 2.1% of pay expenditure. This compares favourably to the agency cap of 3.2% of pay expenditure which has reduced from the cap of 3.7% in 2023/24.

It is recommended that:
I. The Board note the contents of the report and the action being taken to improve performance.

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

Previous consideration

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

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Integrated Performance Report

December 2024 Trust Board meeting with performance to October 2024

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Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

Mean
Process Limit
Improving special cause
Measure
Concerning 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

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

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

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

The name of the Metric

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

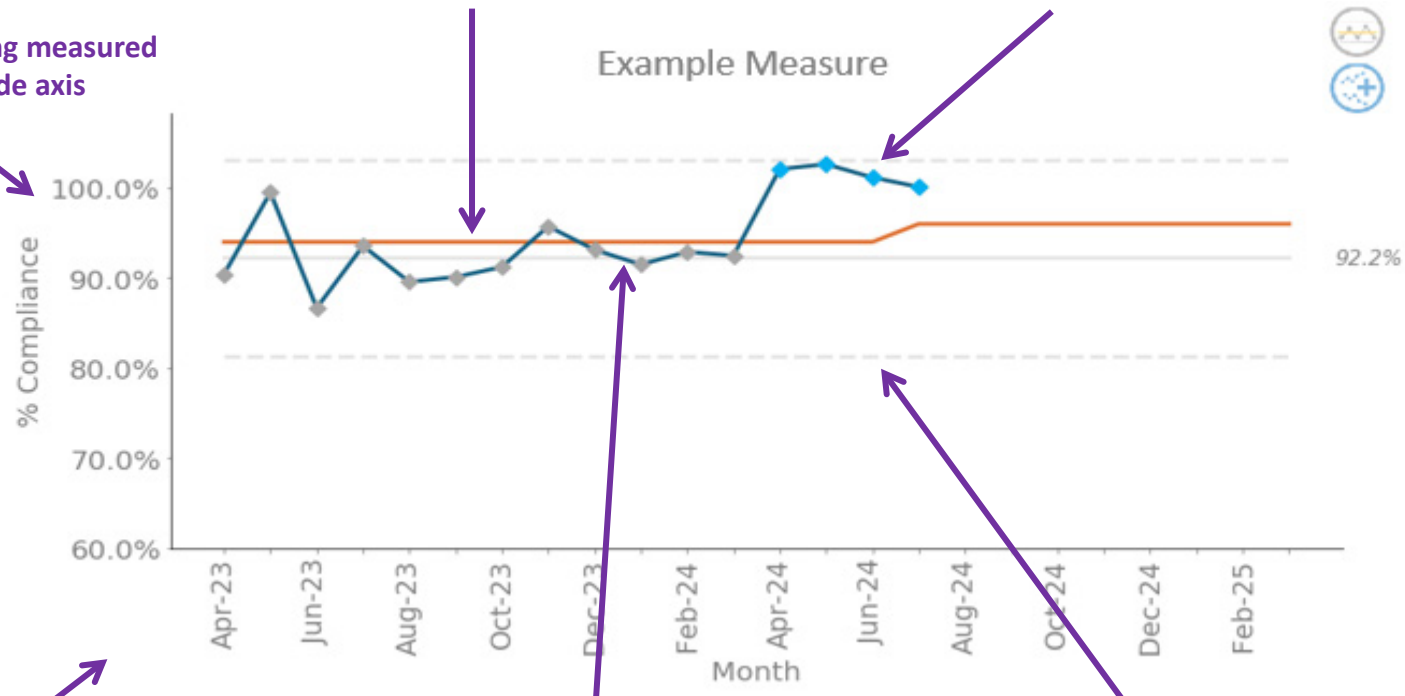
This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

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



The thing being measured goes up the side axis

The trust target is shown as an orange line

Any data points coloured blue are unusual positive points. Orange coloured data points are unusual negative points

Time period goes along the bottom axis

The actual is shown as a blue line.

The grey dotted lines are control limits and show the expected amount of variation

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

SPC KPI Metric Grid

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Vacancies (% FTE)	- Number of violence and aggression incidents toward staff	- Staffing Fill Rate - Registered Nurse - STAR Accreditation all trust (Silver and Above) - Turnover (% FTE)
Normal variation - no recent change	- Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 - Maximum wait of 12 hours as Total Time in Dept - Number of boarded patients - Reduce not meeting criteria to reside to 5% - Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% - 85% theatre utilisation - aggregate - Capped - Sickness Absence (% FTE)	- Staffing Fill Rate - Health Care Assistant - Staffing Fill Rate - Registered Midwife - Staffing Fill Rate - Maternity Support Worker - Complaints per 1000 bed days - C. diff perf against national trajectory - no more than 199 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Category 2 and above) - Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions - Perinatal - Number of Stillbirths - Compliance with 60 minute ambulance turnaround time target - Bed occupancy to 92% - Improve performance against the headline 62-day standard to 70% by March 2025	
Recent positive pattern in the data	- 52 Week Waits - Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) - Eliminate >78 week waits	- Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	

Non SPC Metrics flagged as a concern

Appraisal Compliance (% HC)
I&E Normalised run rate
FRP schemes delivery

Non SPC Metrics

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

Safety & Quality
Operational Performance
People and Culture
Finance

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People & Culture

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Single Improvement Plan - Workforce

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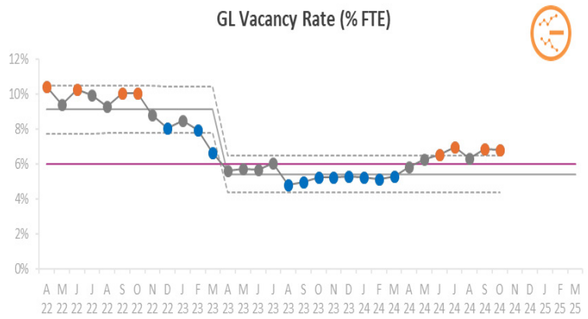
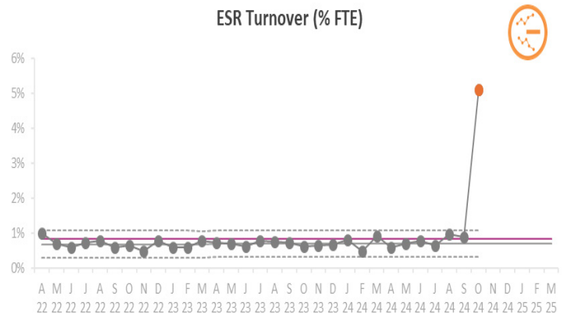
Metric Description		FY2425 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2425	Latest Month Target		
People and Culture	Vacancies (% FTE) (source: General Ledger)	F			≤ 6%		6.85%	M07
	Turnover (% FTE) (annual assessment; ESR in-month reported)	P			≤ 10%		5.11%	M07
	Sickness Absence (% FTE) (annual assessment; in-month reported)	F		⚑	≤ 5.24%		6.76%	M07
	Number of violence and agression incidents toward staff (annual assessment; in-month reported)			⚑	996		113	M07
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				≥ 90%		94.39%	M07
	Appraisal compliance (% HC)			⚑	≥ 90%		88.02%	M07
	Staff Survey: Recommend Trust as place to work (quarterly metric)	F		⚑	≥ 60%		50.99%	Q2

People & Culture - Assurance 1

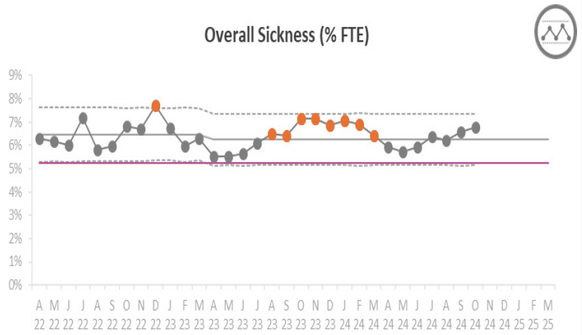
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
6.85%
Variance Type
Recent concerning pattern in the data
Mar 25 Target
≤ 6%
Target Achievement
Will consistently fail target within expected variation



Latest
5.11%
Variance Type
Recent concerning pattern in the data
Mar 25 Target
≤ 10%
Target Achievement
Will consistently pass target within expected variation

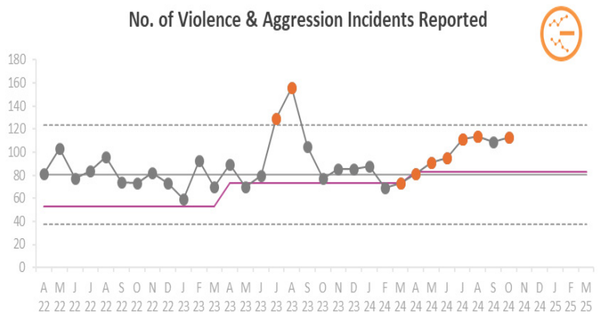


Latest
6.76%
Variance Type
Normal variation - no recent change
Mar 25 Target
≤ 5.24%
Target Achievement
Will consistently fail target within expected variation

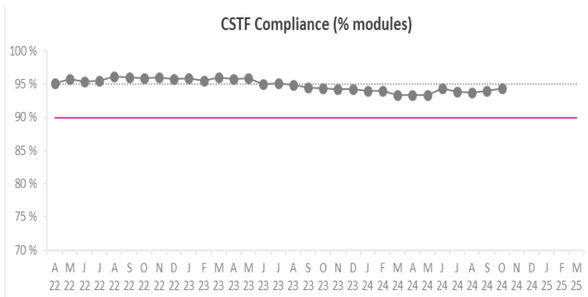
Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancies rates have increased slightly due to ongoing vacancy control measures and more recent vacancy freeze in support of financial recovery.	Actions in month include: Commencement of medical hard to fill Divisional focus groups with Exec support. Continue with targeted resourcing and retention plans where appropriate. Continue with Vacancy Control procedures where appropriate to support financial recovery.	Detailed recruitment and retention action plans are in place for long term or high volume vacancies such as HCA and Hard to Fill Medical recruitment plans in place Divisionally.
Turnover (% FTE)	Turnover has spiked in M7 due to One LSC TUPE transfer and movement of associated staff to East Lancashire Hospitals Trust.		Trust retention plans in place to support high turnover areas such as HCSW.
Sickness Absence (% FTE)	The overall sickness absence rate remained above 6% throughout Quarter 2 and this is slightly higher than the same period last year. Short term sickness has increased slightly in line with the usual seasonal cold and flu spike. It also means that we are off plan with the target of an annualised reduction of 1% by the end of the financial year.	Recruiting to a vacant Occupational Health physiotherapist post will enable a more proactive and timely response for colleagues with musculoskeletal conditions; however the capacity pressures within the psychological wellbeing service are a long-term risk, and an additional psychologist is required to achieve waiting list reduction.	

People & Culture - Assurance 2

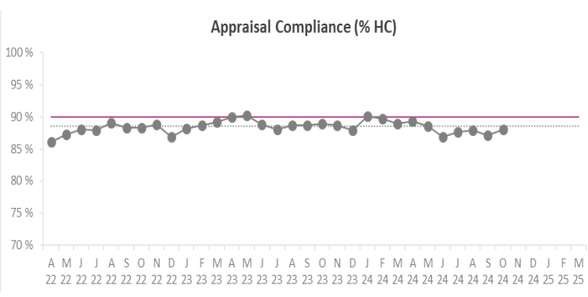
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
113
Variance Type
Recent concerning pattern in the data
Mar 25 Target
996
Target Achievement
Could both pass or fail target within expected variation



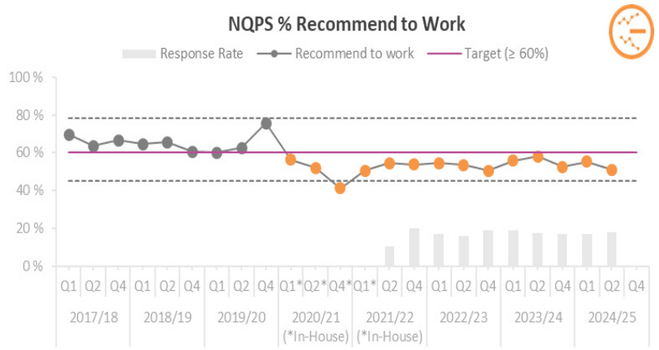
Latest
94.39%
Variance Type
-
Mar 25 Target
≥ 90%
Target Achievement
-



Latest
88.0%
Variance Type
-
Mar 25 Target
≥ 90%
Target Achievement
-

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	The number of reported violence and aggression incidents has increase sightly in M7.	CI and Big Room Work to continue.	Focused continuous improvement work around preventing and reducing incidents is underway in three test areas (Rookwood A, Rookwood B and Medical Assessment Unit Chorley), and the Big Room driving this work, are working collaboratively with the Mental Health Big Room to join up some of the areas of focus.
Core Skills Mandatory Training compliance (% modules)	While overall compliance for Core Skills for the Trust is above 90%, there are areas within the Trust (specific professional groups, SBUs and Departments/Wards and whole metrics) which are not compliant.	Regular actions taken: - Presenting mandatory compliance data at Divisional Workforce Committees - Development of Super Red report - Monthly reminders sent to individual staff - Roll out of new CQC compliance reporting matrix	- Development of remedial action plans by each division in line with Trust risk register actions. - Compliance reports distributed throughout the Trust on a monthly basis. - Health and Safety training compliance data presented at Health and Safety Governance Group - Bi-monthly ETR Committee report
Appraisal compliance (% HC)	Appraisal compliance in month 7 is 88.02%, this is just under 1% improvement since month 6.	The actions taken in month include: A focus on appraisal in the Leaders Forum and delivery of dedicated Managers Update Session on how to undertake appraisal, provide meaningful feedback and ensure colleagues feel valued. Refreshed appraisal policy in draft. Review of number of partially completed appraisals and noncompliance by band. Development of proposed approach to support appraisal rates improving	Planned actions include: Refresh of appraisal documentation and supporting guidance. Targeted communications and support to areas with lowest appraisal completion rates. Supporting teams to establish effective appraisal trees to reduce appraisal burdens for some roles.

People & Culture - Assurance 3



Latest
50.99%
Variance Type
Recent concerning pattern in the data
Mar 25 Target
≥ 60%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work		The NHS Staff Survey is open for responses until the end of November, the focussed actions this month centre around increasing completion rates to ensure we have representative sample of workforce providing feedback on their experience of work.	Actions to be delivered in the next month will include detailed analysis of 2024 NHS Staff Survey data and reporting into Workforce Committee, development of detailed action plan, communicating and engaging with colleagues at all levels regarding their results and encouraging local action plan development and discussion around experience of work.

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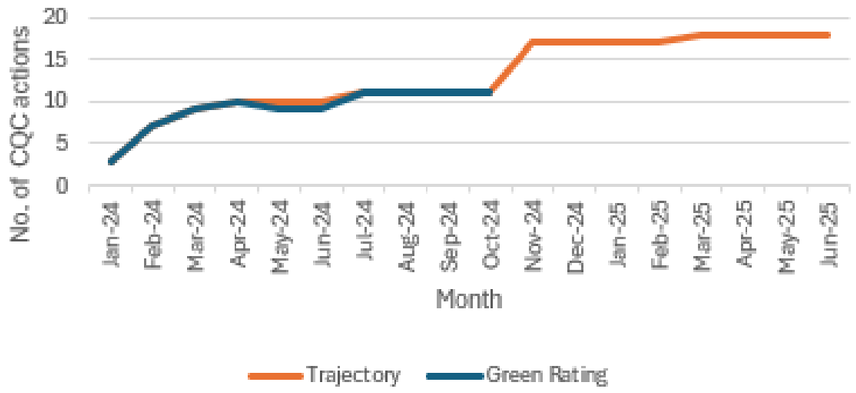
Single Improvement Plan - Safety, Quality & Effectiveness

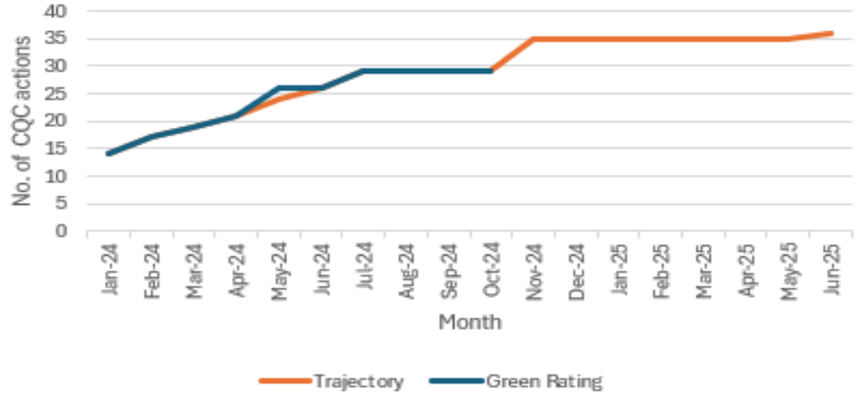
NHS Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-25	Latest Month Target		
CQC	% of must do's from QIP 2023 assessed as Green (i.e. delivered)				18	11	11	Oct-24
	% of should do's from QIP 2023 assessed as Green (i.e. delivered)				35	29	29	Oct-24
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95.0%	95.0%	100.0%	Oct-24
	Staffing Fill Rate - Health Care Assistant				95.0%	95.0%	100.5%	Oct-24
	Staffing Fill Rate - Registered Midwife				95.0%	95.0%	96.6%	Oct-24
	Staffing Fill Rate - Maternity Support Worker				95.0%	95.0%	85.8%	Oct-24
Patient Experience and Involvement	Complaints per 1000 bed days				1.69	1.69	1.09	Oct-24
	STAR Accreditation all trust (Silver and Above)				75.0%	75.0%	88.0%	Oct-24
C Difficile Improvement	C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases				16	16	24	Oct-24
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected					66.4	May-24
	Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected					61.3	May-24
	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected					45.1	May-24
	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected					52.4	May-24
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.48	3.48	3.40	Oct-24
Maternity	Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions				100%	100%	100%	Oct-24
	Perinatal - Number of Stillbirths				0	0	1	Oct-24

Safety & Quality Performance - CQC Assurance



Latest
11
Variance Type
Mar-25 Target
18
Target Achievement

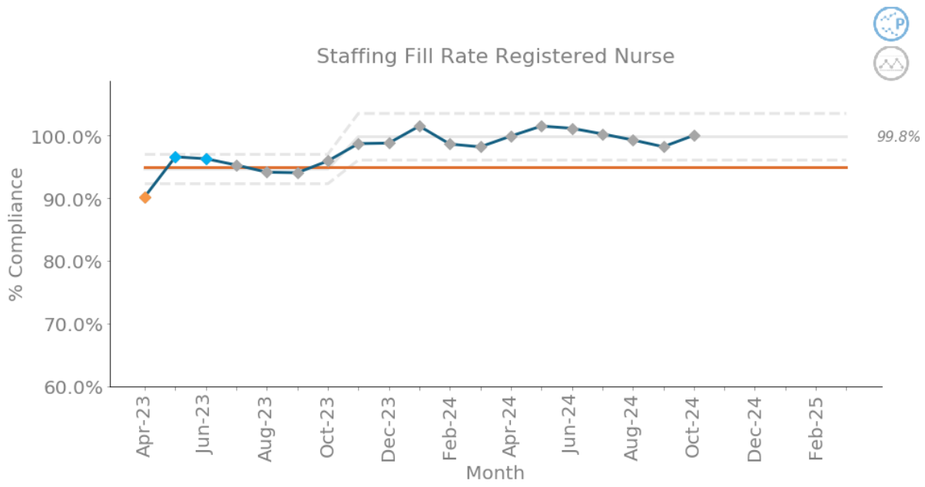


Latest
29
Variance Type
Mar-25 Target
35
Target Achievement

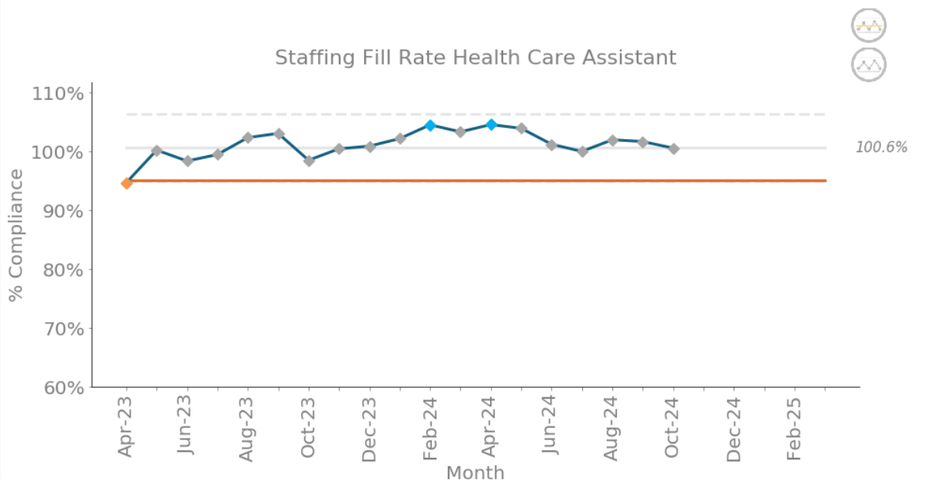
Metric	Summary	Action	Assurance
Number of "Must Do's" from QIP 2023 assessed as Green (i.e. delivered)	From the 18 'Must Do' recommendations, 11 have been assessed as delivered and the themes of the 7 outstanding 'Must Do' recommendations are related to training and appraisal compliance by professional group and CQC core service, medical staff training compliance in urgent and emergency care and medicine, evidence of a timely assessment by a senior decision making in surgery, medical staffing in medicine and documentation specifically in relation to fluid balance and vital signs. A delivery date has been set for each of the outstanding must do's. From the 36 'Should Do' recommendations, 29 have been assessed as delivered and the themes of the outstanding 7 'Should Do' recommendations are related to medical staffing in ED, timely medical review when not being provided care and treatment on the correct medical speciality ward, compliance with infection, prevention and control standards in medicine, evidence of NEWS2 recording in medicine, STAR audit outcomes in ED, equipment and environment maintenance and midwifery staffing. A delivery date has been set for each of the outstanding should do's.	1. Delivery of the actions outlined within the Quality Improvement Plan 2. Use of Single Improvement plan weekly meetings to have director oversight of those actions that have required extension. 3. Escalation to executive leads regarding further actions required to ensure delivery.	1. Quarterly reports to safety and Quality committee on the progress against the delivery of the CQC must and should do's. 2. System Improvement Board scrutiny of the quality improvement plan. 3. CQC monitoring and feedback in place. 4. Key performance metrics identified within the single improvement plan reflect the priorities identified from the CQC inspection.
Number of "Should Do's" from QIP 2023 assessed as Green (i.e. delivered)			

Safety & Quality Performance - Deliver Annual Safe Staffing Requirements Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
100.04%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Will consistently pass target within expected variation

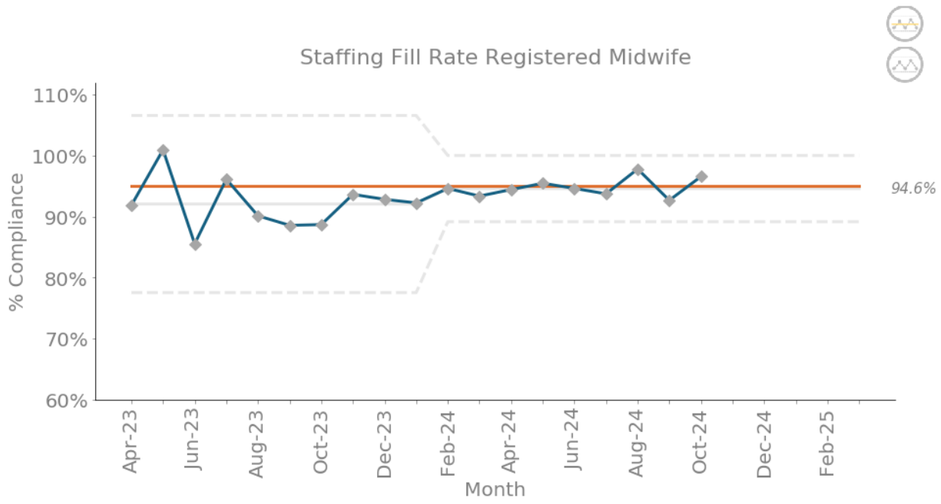


Latest
100.51%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Could both pass or fail target within expected variation

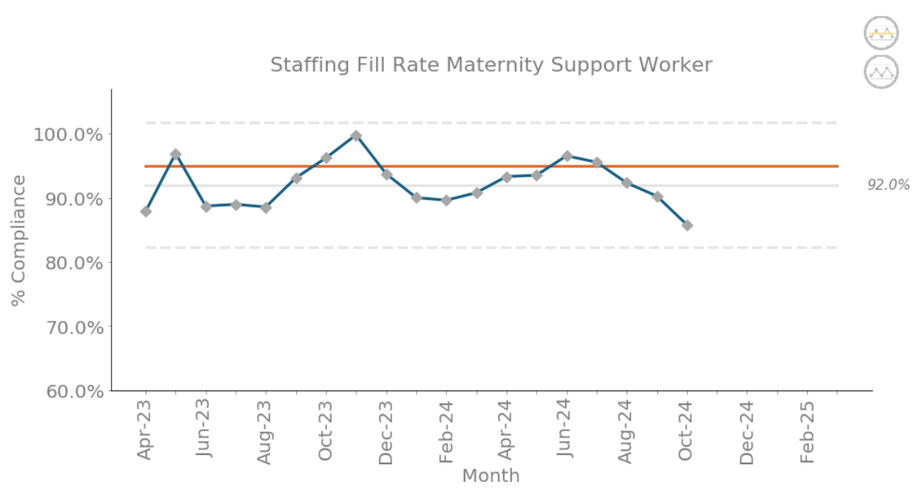
Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for inpatient wards in October was 100%. Chorley District Hospital (CDH) RN fill rate for October was 99%, with Royal Preston Hospital (RPH) RN fill rate being 100%. The need for bank support remains to ensure safety is maintained due to sickness and enhanced care that exceeds headroom. There is now only neurosurgery, ED and CYP that are using small amounts of agency RN when all other internal options have been exhausted. The implementation of strengthened approval processes for bank and agency commenced 2/9/24 and is being monitored through weekly roster reviews by the Divisional Nursing Teams.	1. Ward managers are responsible for safe staffing with oversight from the matron and will convert time to lead to clinical time when required. 2. The transition of international nurses to fully independent is now completed. 3. Safe staffing meetings continue to be conducted daily to ensure a helicopter view is provided and senior input to staffing deployment is in place.	1. The Safety and Quality Committee receive a detailed report on a monthly basis providing assurance of minimal safe staffing levels and fill rate by ward. 2. The Trust is compliant with National Quality Board safe staffing guidance. 3. NHS England 2024 external review of safe staffing conducted and compliant. 4. The overall fill rate on average is between 112.4% and 85.7%. 5. All clinical areas are showing a stable fill rate position. 6. Daily operational staffing meetings in place led by matrons assess and respond to changes in pressure and demand based on acuity and dependency. Red flag reporting and incident reporting forms part of the intelligence collected around safe staffing.
Staffing Fill Rate Health Care Assistant	The HCA staffing fill rate for inpatient wards in October was 101%. Chorley District Hospital (CDH) fill rate for October was 93%, with Royal Preston Hospital (RPH) HCAl fill rate being 103%. The need for bank support remains to ensure safety is maintained. The implementation of strengthened approval processes for bank has been developed and agreed to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff. The new processes commenced 2nd September and are being closely monitored through weekly roster reviews by the Divisional Nursing Teams	1. The vacancy rate within the HCA workforce is leading to increase use of bank and enhanced therapeutic interventions due to a lack of substantive staff. The Priority work is to address the vacancy within HCA to stabilise teams and reduce the reliance on additional colleagues. 2. Weekly roster efficiency reviews are undertaken by the Divisional Nurse Leaders following the introduction of strengthened approval processes for bank use. 3. A review of Band 2 and Band 3 roles is being undertaken inline with national role guidance with a view to strengthening the appeal of the role and career structure. 4. The introduction of apprenticeships into vacancies has commenced in the inpatient wards.	

Safety & Quality Performance - Deliver Annual Safe Staffing Requirements Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



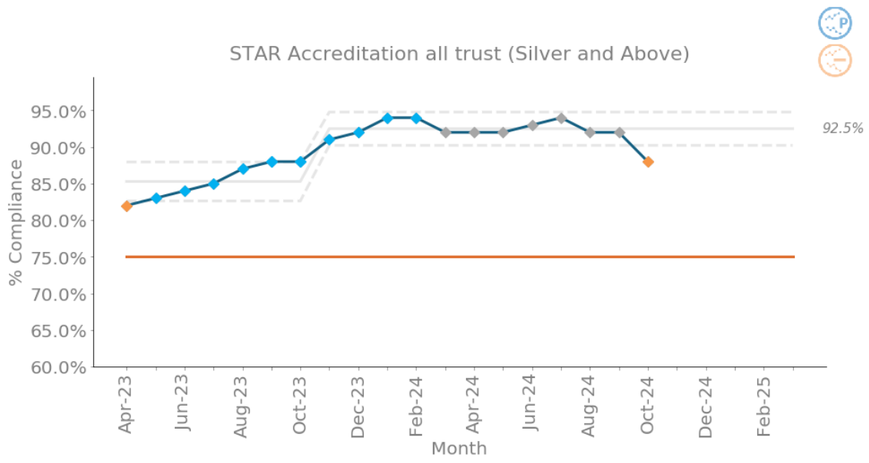
Latest
96.55%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Could both pass or fail target within expected variation



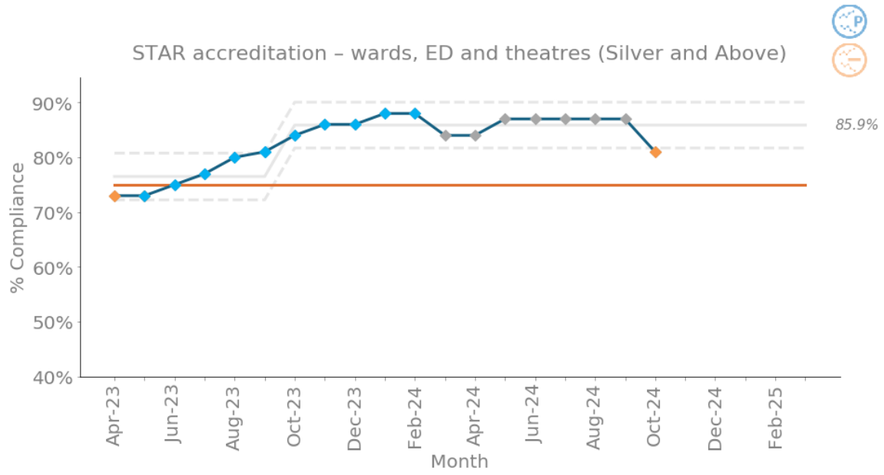
Latest
85.83%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The fill rates for Registered Midwives in October 2024 were (RM) (91%day, 89% night) demonstrates an improving position overall, which is synonymous with the reduction in established midwifery vacancies. Several areas have seen increased sickness absence which has affected fill rates in month and resulted in an increase in bank and agency spend associated with Delivery Suite, Maternity A and B and Maternity Assessment Suite. Fill rates for registered midwives overall have been on an improving trajectory between 86% to 94% in the last 6 months across day and night shift patterns.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Ward managers work clinically in addition to the 80/20 split when required during periods of high activity or reduced staffing. 3. Weekly roster efficiency reviews to ensure appropriate use of bank and agency. 4. Recruitment of regular agency staff to the Trust bank. (5WTE) Ongoing recruitment to fill all vacancies which are tracked using a local trajectory	1. The Trust is compliant with the national Quality Board guidance for safe staffing. 2. NHS England 2024 review completed of safe staffing and confirmed compliance. 3. Monthly detailed reports on safe staffing to the safety and quality committee enable oversight of a triangulated approach to patient and staff outcome measures. 4. Clinical Outcomes are stable. 5. The implementation of strengthened approval and oversight processes for bank and agency approval has been implemented. 6. Approval and sign off of all agency shifts undertaken by the Deputy/
Staffing Fill Rate Maternity Support Worker	The fill rates for Maternity Support Workers in October were 79% day and 95% night. This is as a result of Long term sickness on maternity A (3.5 WTE) which equates to 66% of the unregistered establishment. To maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Weekly roster efficiency reviews to ensure appropriate use of bank and agency. 3. Where necessary staff are moved from day to night shifts based on a clinical judgement at the time of sickness. 4. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory. 5. Band 2 and 3 positions and career pathway now in place in maternity to retain quality colleagues and provide a career pathway. 6. The first two apprentice midwives have commenced in 2024.	1. The Trust is compliant with the national Quality Board guidance for safe staffing. 2. NHS England 2024 review completed of safe staffing and confirmed compliance. 3. Monthly detailed reports on safe staffing to the safety and quality committee enable oversight of a triangulated approach to patient and staff outcome measures. 4. Clinical Outcomes are stable. 5. The implementation of strengthened approval and oversight processes for bank and agency approval has been implemented.

Safety & Quality Performance - Quality Assurance



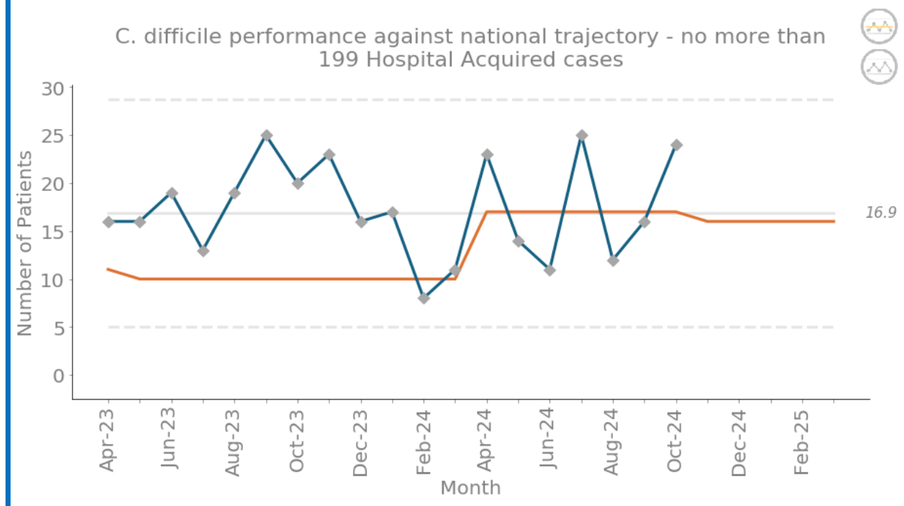
Latest
88.00%
Variance Type
Recent concerning pattern in the data
Mar-25 Target
75.00%
Target Achievement
Will consistently pass target within expected variation



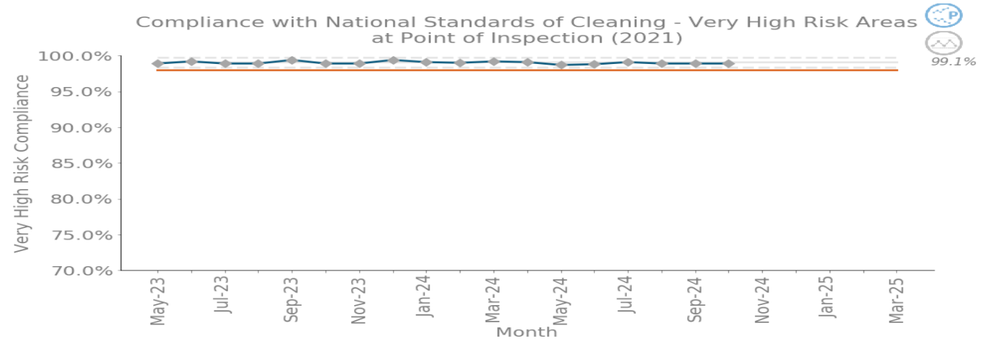
Latest
81.0%
Variance Type
Recent positive pattern in the data
Mar-25 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

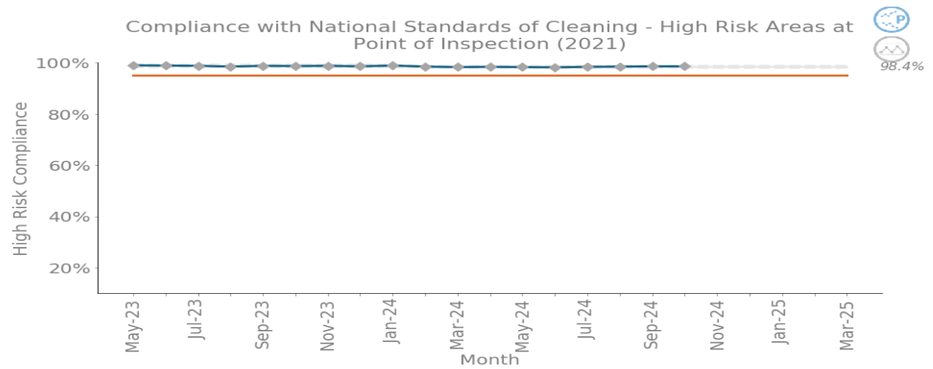
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above) STAR accreditation – wards, ED and theatres (Silver and Above)	There are 124 clinical areas registered for the STAR Quality Assurance Framework, of which all 124 have received STAR accreditation visits. There are no clinical areas with a red rating, 15 areas with an amber rating and 109 areas rated green. This results in 15 bronze stars, 27 silver stars and 82 gold stars. There are 88% of areas rated silver or above. During October, 5 clinical areas had a reduced STAR rating from gold/silver stars to bronze star as they did not achieve the mandated critical standards.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance processes and via STAR monthly reviews and STAR accreditation. visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings, the always safety first learning and improvement group and estates and facilities partnership board. 3. STAR accreditation visits are scheduled on a risk rated frequency depending on star rating, areas with a bronze star rating are reassessed within 3 months. 4. Implementation of mandated fundamental standards are now implemented, preventing progress to a green outcomes unless fundamental standards are met.	1. The STAR report is shared within the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness. 3. The AMaT system records the STAR audit data enables oversight and management of improvement actions. 4. There is a business intelligence STAR page to ensure unit managers can access data and view peer department activity. 5. Monthly STAR reports are considered through the NMAHP Board.

Safety & Quality Performance - C Difficile Improvement Programme Assurance



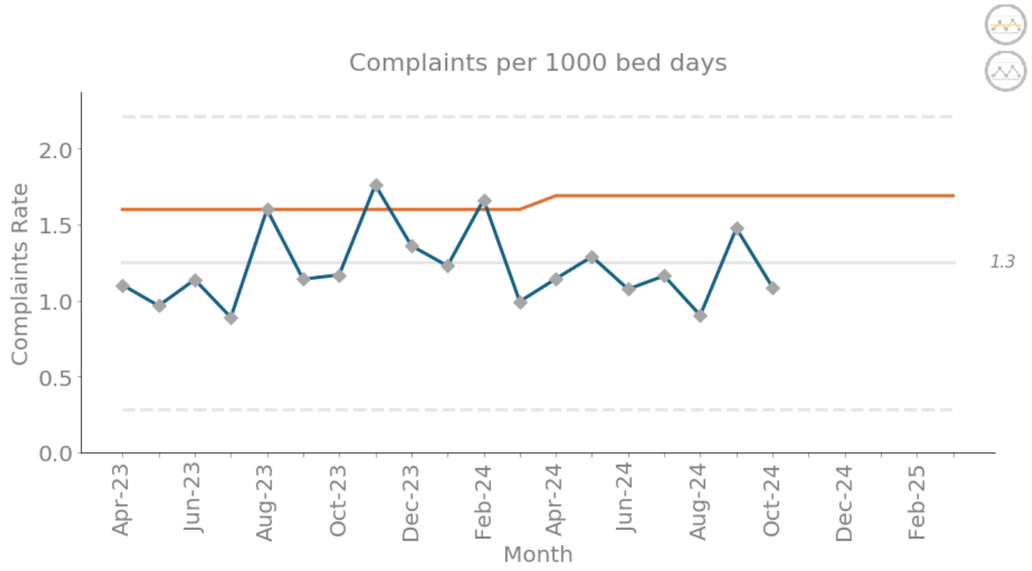
Latest
24
Variance Type
Normal variation - no recent change
Mar-25 Target
16
Target Achievement
Could both pass or fail target within expected variation





Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases	The Trust is currently 9 cases higher than the national trajectory as of October 2024. The contributing factors to this are: 1. Increase in C. difficile prevalence Nationally 2. Patient non-compliance with medical advice, 3. Non-adherence to antimicrobial guidance, 4. Variable compliance with IPC policy and guidance, 5. Restricted isolation facilities for the number of infectious patients admitted into the Trust 6. Boarding patients due to increase in demand in service within the Trust 7. Ageing estate which is proven difficult to clean and maintain causing spores to live in the environment 8. Sewage incidents due an aging system that is regularly blocked 9. Non-compliance with National Cleaning Standards (Domestic services 15 areas compliant) 10. Limited access to funding for remedial / maintenance and capital works	1. Develop the business case to become fully compliant with the National Cleaning standards (2021) 2. To annually review remedial and capital workstreams in line with capital funds, prioritising IPC risks. 3. Continued oversight of standard adherence. 4. Relaunch of estates and facilities partnership meeting to ensure estates work and IPC priorities are progressed. 5. Requested NHS England external review of BAF and IPC practices. This remains outstanding at this time. 6. Introduction of mandatory fundamental standards in IPC as part of STAR.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard including monitoring of cleaning standards. 3. IPC monthly audit plan. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into health and safety Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. ICB & NHSE IPC Collaborative meetings. 7. Fogging compliance data monitored. 8. Reporting of hospital acquired infection on Datix to monitor themes and trends and enable deep dive reviews to identify learning.

Safety & Quality Performance - Patient Experience and Involvement Assurance



Latest
1.09
Variance Type
Normal variation - no recent change
Mar-25 Target
1.69
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	The number of complaints reduced by 132 when comparing 2022/23 to 2023/24 equating to 27.1% reduction. The target line represents the average number of complaints received over the previous 3 years. With the exception of 3 data points complaints received have remained below the previous 3 year average. The complaint incidence is measured against activity and presented as a per thousand bed day metric to ensure there is a recognition of any increase in activity. The theme of complaints relates to the Urgent and Emergency Pathway, communication, complex clinical presentations and unexpected clinical outcomes. The patient safety partners employed within the organisation are playing a critical role in reshaping the organisations approach to meaningful involvement and connection with patients and families. This is intended to create better relationships, build trust and confidence in our services and improve peoples overall experience. The patient experience and involvement strategy is in year 2.	1. Implement the patient experience and involvement strategy 2. Implement Patient Safety Incident Response Framework with a focus on meaningful patient and family engagement. 3. Implement the People Plan. 4. Identify an approach to training in meaningful engagement for the organisation. 5. Continued focus on local early resolution.	1. Twice annual patient experience reports to safety and Quality committee. 2. Friends and family reporting in place on paper and text for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses.

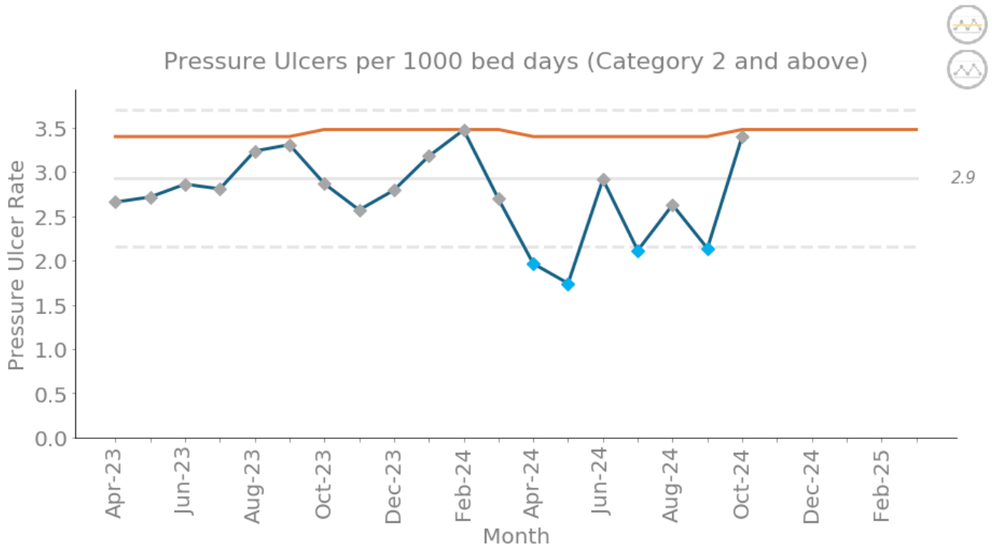
Safety & Quality Performance - Always Safety First Assurance

NHS Lancashire Teaching Hospitals NHS Foundation Trust

	Latest	Achievement
Hospital Standardised Mortality Ratio (56 Basket – Adult)	66.4	Within Upper and Lower Control Limits
Standardised Mortality Rate (All Diagnoses – Adult)	61.3	Within Upper and Lower Control Limits
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	45.1	Within Upper and Lower Control Limits
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	52.4	Within Upper and Lower Control Limits

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

Safety & Quality Performance - Always Safety First Assurance

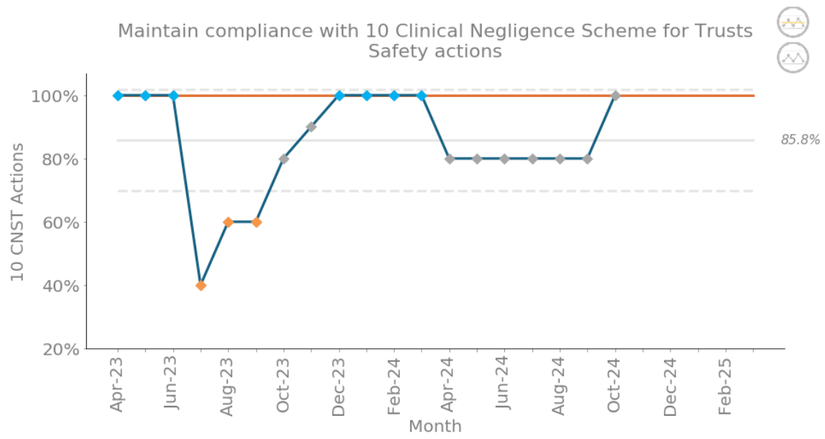


Latest
3.40
Variance Type
Normal variation - no recent change
Mar-25 Target
3.48
Target Achievement
Could both pass or fail target within expected variation

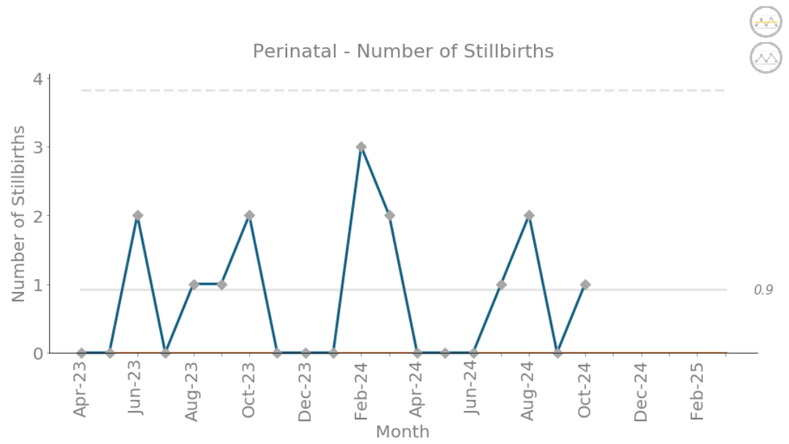
Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers are considered a proxy of care delivery. The target line represents the average number of pressure ulcers in the previous three years. With the exception of one month performance in this area is consistently improved this is despite prolonged lengths of stay in ED that often contribute toward the development of pressure ulcers. There is also a direct correlation to the number of patients spending extended periods of time reducing in hospital linked to the development of intermediate care options outside of hospital. This work will remain a priority.	1. Organisational pressure ulcer improvement plan lead by the Deputy Chief Nursing Officer 2. Continued focus on Operational Performance Single Improvement plan. 3. STAR quality assurance fundamental standards includes intentional rounding which is linked to pressure relief treatment. 4. Education and awareness of pressure ulcer prevention continues.	1. Always Safety First strategy reporting twice yearly to safety and quality committee. 2. Always Safety First committees at divisional level responsible for overseeing the implementation of the codesigned pressure ulcer improvement programme. 3. Monitoring of pressure ulcer incidence continues to be recognised as a priority metric.

Safety & Quality Performance - Maternity Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
100.0%
Variance Type
Recent positive pattern in the data
Mar-25 Target
100.00%
Target Achievement
Will consistently fail target within expected variation



Latest
1
Variance Type
Recent positive pattern in the data
Mar-25 Target
0
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	The position for CNST MIS year 6 is detailed within the maternity neonatal report presented to Board on a bi monthly. In November 2024, the CNST standards were validated by the local Maternity and Neonatal System LMNS and signed off against 7/10 standards. The remaining 3/10 standards are on track to meet the recommendations but cannot be formally signed off until the end of the reporting period which ends on the 30 November 2024. It is expected all 10 standards will be achieved in the deadline.	1. Delivery of the Maternity Neonatal Improvement plan.	1. Monthly reporting to safety and quality committee. 2. ICB Local Maternity Neonatal System validation of CNST delivery of standards.
Perinatal - Number of Stillbirths	The stillbirth rate in England was updated in October 2024 (MBRRACE) to 3.9 per 1000 births. The government ambition to achieve a 50% reduction in the stillbirth rate by 2025 equates to a rate of 2.6 stillbirths per 1,000 births. LTHTR stillbirth rate is 2.8 per 1000 births.	1. Implementation of the 10 CNST maternity neonatal safety standards.	1. Monthly reporting to safety and quality committee. 2. Peer comparison data included within the reporting 3. National embrace reporting provides overview of national themes to ensure learning is understood nationally. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards.

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Financial Sustainability

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Single Improvement Plan - Financial Sustainability

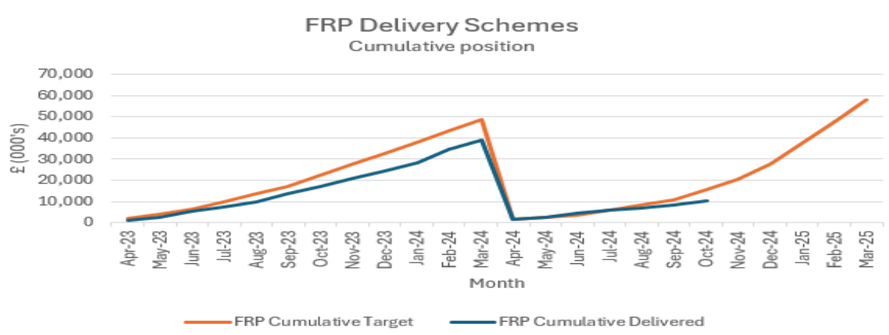
Lancashire Teaching Hospitals
NHS Foundation Trust

Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target (£ 000's)			Latest YTD Actual (£ 000's)	Latest Month
				Concern	Mar-25	Latest YTD Target		
Finance	I&E Normalised run rate					-7273	-15510	Oct-24
	FRP schemes delivery				58040	15730	10344	Oct-24

Single Improvement Plan - Financial Sustainability - Assurance

Lancashire Teaching Hospitals NHS Foundation Trust

Latest YTD Actual (,000s)
-15,510
Latest YTD Target (,000s)
-7,273
March 25 YTD Target (,000s)
-



Latest YTD Actual (,000s)
10,344
Latest YTD Target (,000s)
15,730
March 25 YTD Target (,000s)
58,040

Metric	Summary	Action	Assurance
I&E Normalised run rate	The Trust had submitted the final plan in line with the NHSE control total, a deficit of £21.9m. In month 6 the Trust received funding to cover the deficit the Trust now has a break-even plan. At month 7 the Trust has a deficit of £15.5m an adverse position of £8.2m against a planned deficit of £7.3m. The main variances to plan are: - £5.4m variance to Financial Recovery Plan Target - £2.6m shortfall on income from urgent and emergency care capacity and investment funding to support frailty and intermediate care The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - capacity issues resulting in elective, day case and out patient income under performance The Trust is reviewing its forecast recognising that it is a high risk plan with a number of efficiency schemes not yet delivering to plan, risks that have materialised since the plan was set and continued operational pressures.	The Trust has appointed a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has been part of this review. The ICB has commissioned work into the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE and the Trust has committed to further grip and control measures to manage the in year position. The Trust is reviewing the opportunity for further external support in Q4 to support specific financial recovery plan workstreams. Divisions will need to recover their financial performance by delivering improvements in their current run rates.	Turnaround Director ICB Review of UEC Pathway I&E Interventions and control measures ICB System Improvement Director Review
FRP schemes delivery	The Trust's objective to reach financial balance on a recurrent basis by the end of the three year period (2026-27) will require delivery of an ambitious and very challenging financial recovery plan. In 2024-25 a gap of £58m will need to be mitigated. Of this £8.3m will be closed through income/productivity contribution, £8.3m through system optimisation/risk and a balance of £41.4m (5%) will be delivered through core cost improvement. In month 7 the Trust has delivered £10.3m year to date, which is 66% of the plan of £15.7m however 51% of this was non-recurrent. Annually £16.1m; (£11.5m recurrently) has been delivered towards the £58m target which is 28%.	The Trust has appointed a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure , governance and reporting has been part of this review. The Trust recognises that it will require additional external support to help with the delivery of the FRP as well as drafting the outline for the 2025/26 programme. Support has been approved for procurement and contract management and the Trust is reviewing support for other specific workstreams. The Trust has engaged with the NHSE regional diagnostics team to support the improvement programme in this area.	Turnaround Director Weekly Finance Recovery Board Meetings as part of programme rest ICB System Improvement Director Review

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Operational Performance

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Single Improvement Plan - Operational Performance

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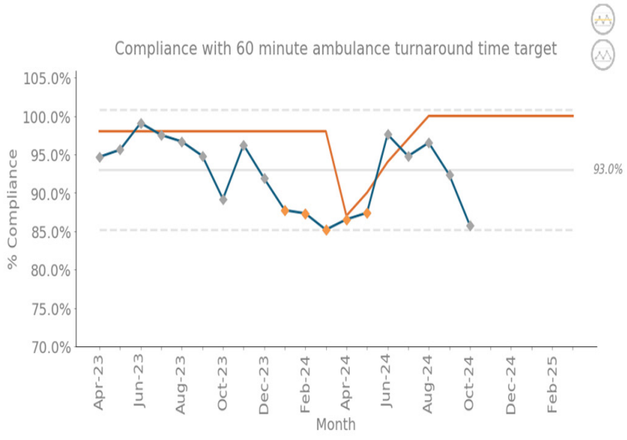
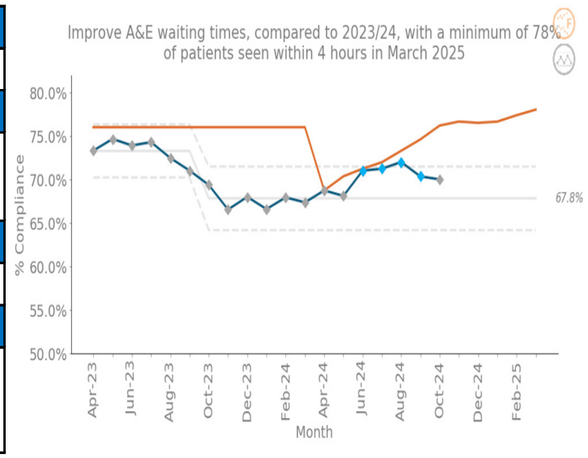
Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-25	Latest Month Target		
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100%	100%	85.7%	Oct-24
	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	F		⚑	78%	76.2%	70.0%	Oct-24
	Maximum wait of 12 hours as Total Time in Department	F			2%	5.2%	10.2%	Oct-24
UEC Flow	Bed occupancy to 92%				92%	93.5%	95.4%	Oct-24
	Number of boarded patients	F		⚑	0	0	26	Oct-24
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5%	F		⚑	5%	5%	10.6%	Oct-24
Elective (diagnostics)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	F			98%	54.6%	46.7%	Oct-24
Elective (long waits)	52 week waits	F		⚑	0	1062	1662	Oct-24
	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	F		⚑	0	0	29	Oct-24
	Eliminate >78 week waits	F			0	0	0	Oct-24
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped	F			85%	80.9%	81.1%	Oct-24
Elective (Cancer)	Improve performance against the headline 62-day standard to 70% by March 2025				70%	66.0%	63.7%	Oct-24
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026				77%	77.0%	82.4%	Oct-24

Operational Performance - UEC Assurance

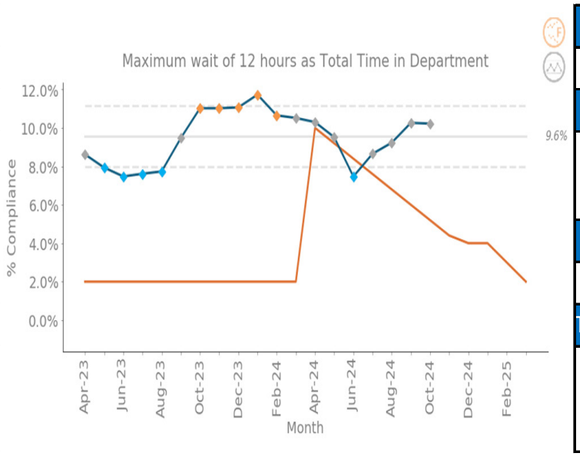
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
85.7%
Variance Type
Normal variation - no recent change
Mar 25 Target
100.0%
Target Achievement
Could both pass or fail target within expected variation



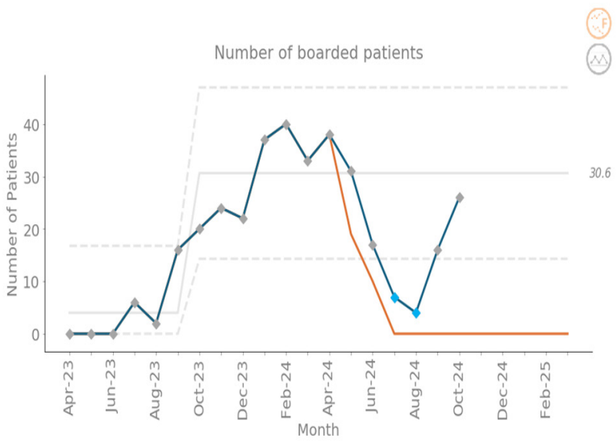
Latest
70.0%
Variance Type
Normal variation - no recent change
Mar-25 Target
78.0%
Target Achievement
Will consistently fail the target within expected variation



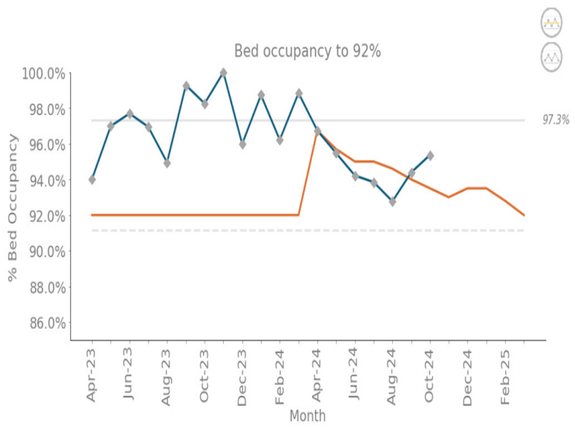
Latest
10.20%
Variance Type
Normal variation - no recent change
Mar-25 Target
2.00%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In October, 388 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, an increase of 3 from last month. 338 patients waited over 60 minutes to be handed over from NWAS to the Trust in October 24, an increase of 158 compared to September. The current 60 minute compliance position is just within expected variation but is expected to consistently fail the target.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for October 24 indicates that the Trust is consistent with national performance of 85.7% and marginally below the NW performance position 86% of handovers within 60 minutes.
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard had shown an improvement for the last 3 months, however performance has deteriorated slightly in September to 70.3% and in October to 70.01%.	The UEC Improvement programme is focusing on reducing the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly.	The current time to triage is 25 minutes with time to treatment at 156 minutes. Both show a positive downward trend, however triage times have increased in October The overall SDEC utilisation trend indicates that @ 31% of non elective activity is referred into SDEC. The Trust is below the national average position for October of 73.0% and ranked 8th out fo 20 Trusts in the NW Region. There has been a recent positive pattern in the data with October showing a sustained position comparable to September.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted) in ED decreased slightly to 10.2% compared to September at 10.25%. Performance had been showing a downward trend to June 24, but the percentage waiting over 12 hours has increased over the last 4 months. Performance remains within expected variation.	The UEC improvement programme is focusing on reducing length of stay via improving board and ward round standards and driving down the days patients spend in hospital when they no longer require inpatient care.	Overall Bed Occupancy is at 95.4%, with a range from 93% - 97% in the current year. The level of boarded patients continues to rise with October at an average of 26 patients per day, however it is still lower than the high of 31 in April 2024. Comparison within Model Health System re 12 hour ED LOS indicates the Trust is above the provider median and within Quartile 3.

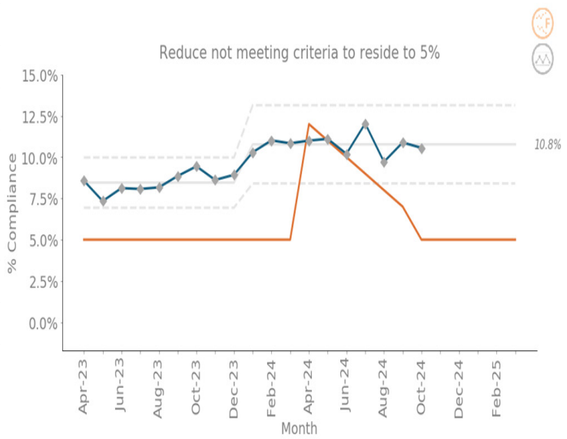
Operational Performance - UEC Assurance



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



Latest
95.4%
Variance Type
Normal variation - no recent change
Mar 25 Target
92.0%
Target Achievement
Could both pass or fail target within expected variation

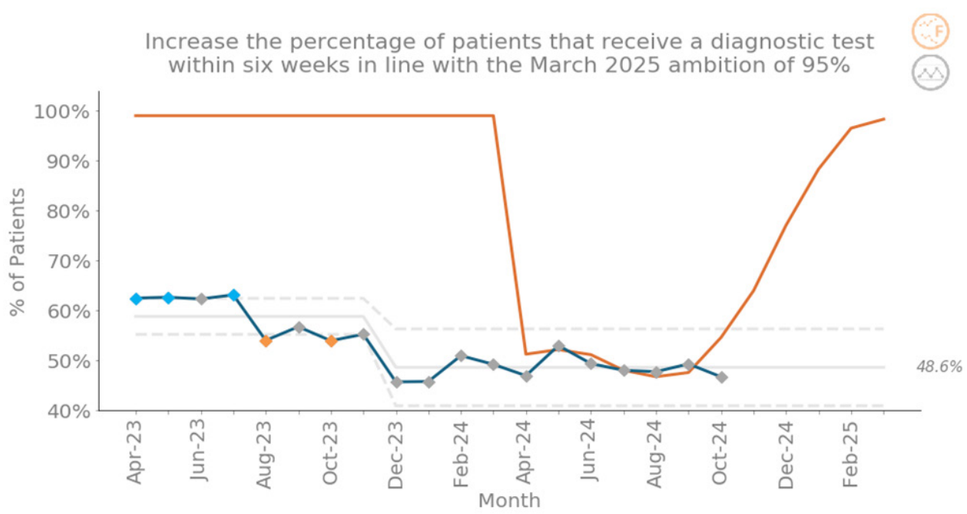


Latest
10.6%
Variance Type
Normal variation - no recent change
Mar 25 Target
5%
Target Achievement
Will consistently fail the target within expected variation

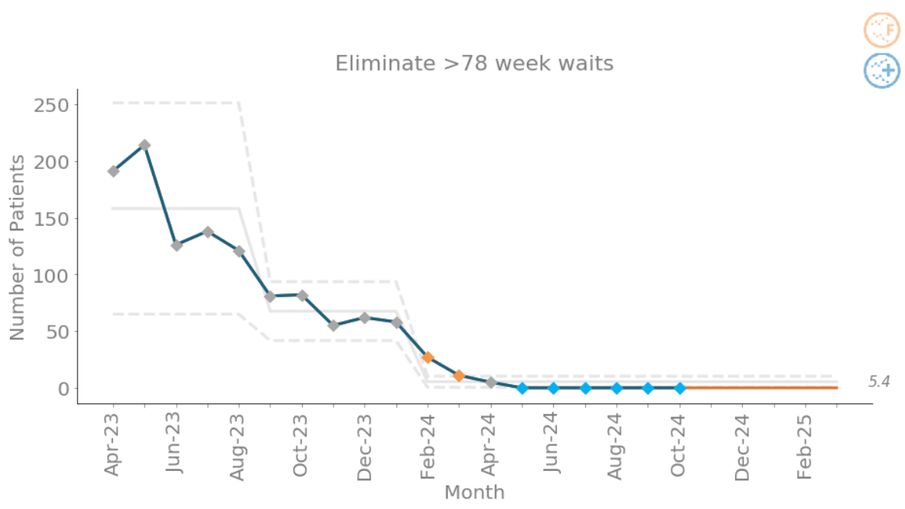
Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 26 patients were boarded each day across both sites during October with 834 associated bed days. This is an increase compared to the September position of 16 patients per day. These are predominantly medical patients requiring admission to an acute medical ward. The current position is within expected variation but will consistently fail the target.	A focus on maximising use of the discharge lounge to reduce the need for boarding.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed Occupancy 92%	Overall Bed Occupancy is at 95.4%, with a range from 93% - 97% in the current year. Analysis of the recent run of performance indicates the Trust could pass or fail the target	Actions to mitigate high occupancy and use boarded/escalation beds of focus on improving ward and board round processes, increasing the use of Same Day Emergency Care (SDEC) facilities, improved discharge processes and mobilisation of the new AMU model of care. However, it should be noted that all improvement areas will see incremental improvements throughout the course of the financial year.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Reduce NMC2R to 5%	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) has decreased from last month's position of 10.9% to 10.6% in October 24. The current position is within expected variation but is expected to continue to fail the national target of 5%.	There has been good utilisation of available capacity in the Home First service, but changes to the commissioning model for the Community Healthcare Hub (CHH) at Finney House have caused some delay to decision making as part of the discharge pathway. The Trust is working with system partners to resolve. Further data analysis is required relating to the number of bed days occupied whilst NMCTR.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Operational Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
46.7%
Variance Type
Normal variation - no recent change
Mar 25 Target
98.0%
Target Achievement
Will consistently fail the target within expected variation

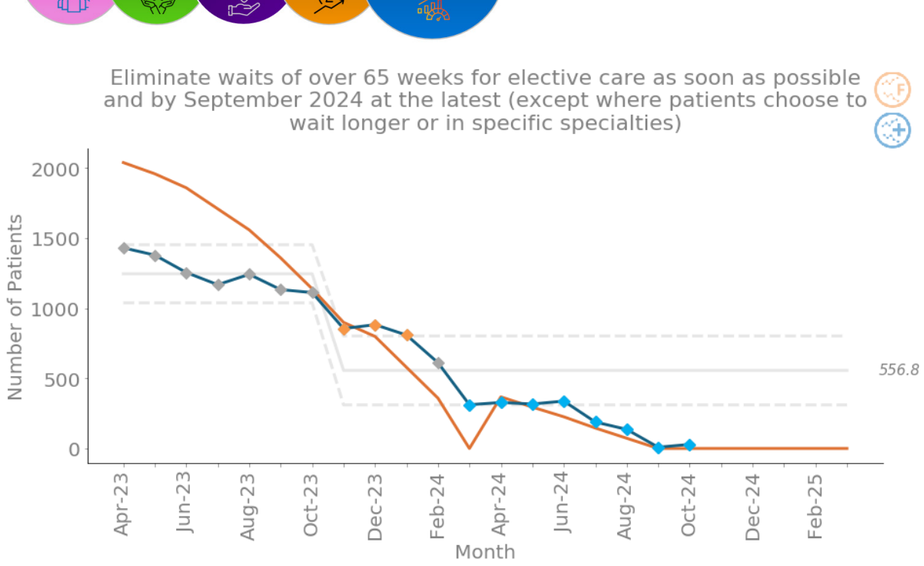


Latest
0
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation

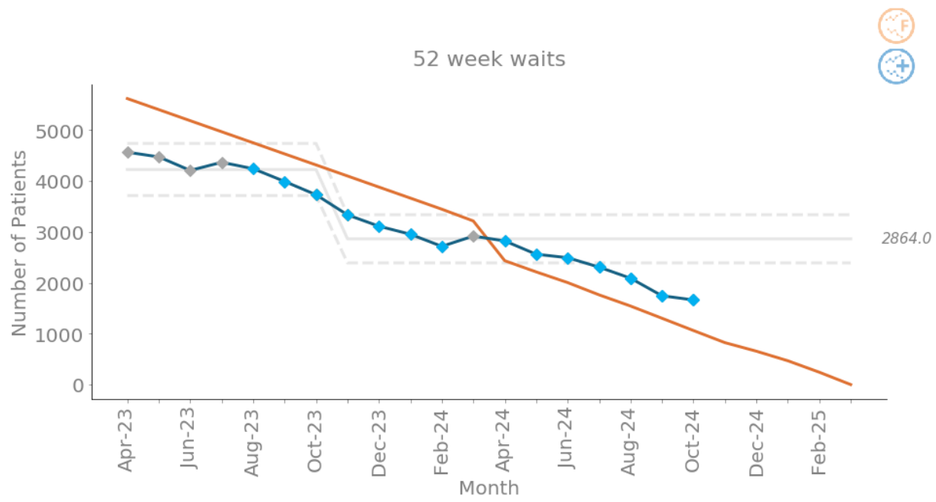
Metric	Summary	Action	Assurance
Increase the % of patients that receive a diagnostic test within 6 weeks	Diagnostics under 6 week performance was 46.7% in October compared to the September position of 49.3%, a deterioration of 2.6%. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance is within expected variation but expected to consistently fail the target. Review of the latest published data (Sept 24) indicates that	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. A business case for capacity to clear the backlog has been agreed, together with longer term plans as part of the single improvement plan, to ensure capacity meets demand at modality level going forwards. The Sherwood Unit opened at the end of September providing additional Endoscopy capacity. Comparison to 2023/24 indicates that the Trust is delivering on average 1,119 more tests per month Apr-Sept 2024 compared to same period is 2023.	The Diagnostic Improvement group is focusing on capacity optimisation, productivity, transformation and system working. Weekly focussed PTL management meetings have been implemented. LTH is the second worst performing NHS Trust in the NW region, worst performing Trust in the ICB and significantly below the national average of 77.3%.
Eliminate > 78 Week Waits	The end of October 24 position was 0, This position has been maintained since May 2024.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Close monitoring of the L&SC long waiting RTT performance is ongoing.

Operational Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



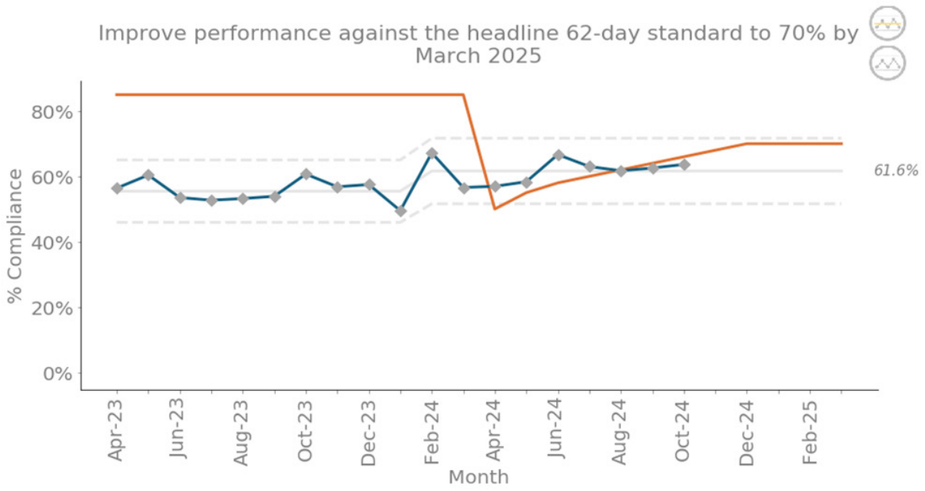
Latest
29
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation



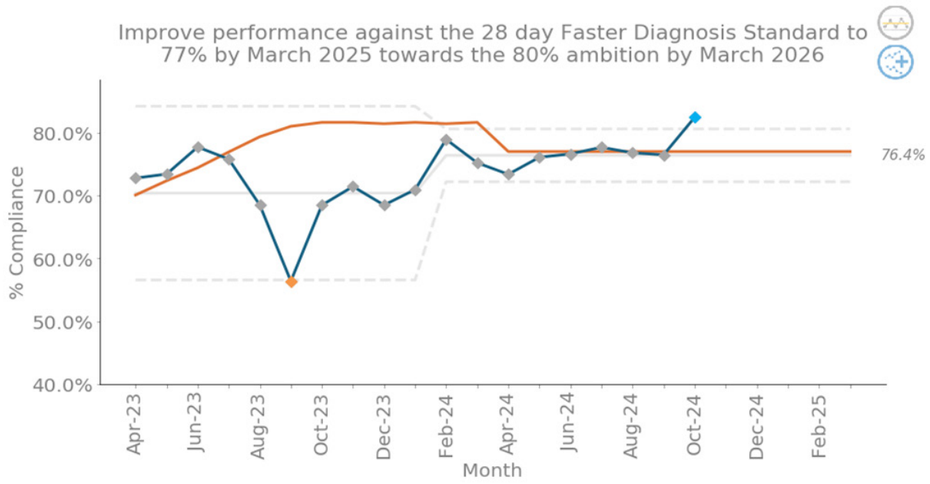
Latest
1662
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Eliminate > 65 Week Waits	The downward trend in over 65 week waiters has deteriorated slightly in October with a position of 29 due to capacity shortfalls. There is a recent positive pattern in the data, however analysis would suggest that the target may be consistently failed.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is underway and once complete, capacity gaps will be appraised against benchmarking productivity opportunities. Comparison to the latest NW region position indicates that the Trust is currently 11th out of all acute and specialist trusts and 4th out of acute Trusts in terms of the overall number of 65 week waiters
Reduce the number of > 52 Week Waits	The downward trend in over 52 week waiters has been continued into October with a position of 1662, a further reduction of 83 from September. There is a recent positive pattern in the data, however the target may be consistently failed.	Capacity & Demand modelling is to be undertaken for all specialities and sub specialities. Focus on DNA reduction, PIFU and theatre utilisation is ongoing to maximise capacity.	Local monitoring of all speciality RTT clock stop/performance is undertaken via fortnightly Performance Recovery Group

Operational Performance - Cancer Assurance



Latest
63.7%
Variance Type
Normal variation - no recent change
Mar 25 Target
70%
Target Achievement
Could both pass or fail target within expected variation



Latest
82.4%
Variance Type
Recent positive pattern in the data
Mar 25 Target
77%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
62 Day Cancer Standard - 70% Target	Performance to the end of October (currently unvalidated and expected to meet the target) is consistent with previous months, slightly below the monthly target of 66%. Analysis shows a recent positive pattern in the data, the target may or may not be achieved.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 67.2% (Sept 24). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
28 Day Faster Diagnosis - 77% Target	Performance to the end of October (currently unvalidated and expected to meet the target) has shown an improved position and is 5.4% above the annual target of 77%. Analysis indicates that the target may or may not be achieved.	Close monitoring of diagnostic turnaround times and associated capacity and demand is underway. Monitoring of opportunities to manage demand is ongoing.	The Trust is currently above the latest national average performance of 74.8% (Sept 24). Close monitoring turnaround times via the Diagnostic Improvement Group

12. GOVERNANCE AND COMPLIANCE

12.1 ANNUAL HEALTH AND SAFETY REVIEW REPORT

Other S Cullen 14:50

Item for assurance

REFERENCES

Only PDFs are attached

12.1 - Annual Health and Safety Paper November 2024 Final.pdf

Board of Directors

Health and Safety Annual Update			
Report to:	Board of Directors	**Date:**	5 December 2024
Report of:	Chief Nursing Officer	**Prepared by:**	C. Morris, H. Ugradar, M. Cowburn

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

Executive Summary:

The purpose of this paper is to provide the Board of Directors with an overview of the management of Health and Safety at Lancashire Teaching Hospitals during 2023/2024 in line with legislative requirements as overseen by the Health and Safety Governance Group. The Safety and Quality committee have reviewed and scrutinised the report.

The paper also summarises the prevailing legislative framework within which Health and Safety concerns are managed and addressed and outlines the local governance arrangements that underpin Health and Safety management within the Trust.

The paper confirms that in order to meet the requirements of the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work 1999 the Trust has a number of processes in place including:

- An up to date Health and Safety Policy.
- Competent persons for Health and Safety.
- An established Health and Safety Governance Group that considers all aspects of Health and Safety with information related to activities overseen by its subgroups.
- An established Health and Safety Representatives Committee enabling consultation and engagement with union health and safety representatives.
- Risk assessment and risk register process established.
- Health and Safety Training.

A review of incidents, risks and audit intelligence identifies learning across a number of Health and Safety themes e.g. increasing workplace stress/demands, ageing estate challenges, violence and aggression, slips, trips and falls, ligature risks, sharps disposal, waste management, decontamination of equipment, ventilation, moving and handling, equipment management, safe storage of equipment, food storage and fire safety.

While internal and external assurances can be provided for several areas, significant challenges persist. These include delivering the Health and Safety agenda amidst long term sickness of the Health and Safety Governance Manager, financial constraints, an ageing estate, increasing staff workplace stress/demands, and ageing equipment.

In October 2024, Risk ID 2075 was identified, highlighting operational fragility due to reliance on a single Band 7 substantive lead within the Health and Safety Governance Team. Despite temporary measures to address immediate gaps, this dependency poses risks to regulatory compliance, risk monitoring, and governance oversight. A benchmarking exercise is underway to compare Health and Safety Governance provisions across Trusts in Lancashire and South Cumbria, with the goal of identifying sustainable strategies to enhance resilience and ensure governance continuity.

To address ongoing challenges, the Associate Director of Safety and Learning is working with Estates and Facilities colleagues to revisit the Health and Safety Single Improvement Plan. Central to this initiative is the development of a Health and Safety Dashboard to enhance governance arrangements and provide actionable insights for forward planning. While this tool is intended to support the Trust in maintaining compliance with legislative requirements while operating within financial constraints, it is important to note that its development will require time and careful planning to ensure its effectiveness and integration into existing processes.

To further strengthen governance and enhance understanding of roles and responsibilities and legislative obligations related to Health and Safety, a dedicated training session led by an external expert was delivered to the Board of Directors during a Board Development Day in July 2024.

It is recommended that the Board of Directors:

i. Note the contents of the report and that the report has been reviewed and scrutinised at Safety and Quality committee, confirm it is assured of the actions being undertaken to mitigate Health and Safety risks, despite ongoing challenges.
ii. Note and endorse the review of the Health and Safety Single Improvement Plan and the development of a Health and Safety Dashboard as key initiatives to enhance governance arrangements across the organisation.

Appendix 1 – Tables and Figures

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

1. Background

1.1 The purpose of this paper is to provide the Board of Directors with an overview of the management of Health and Safety at Lancashire Teaching Hospitals during 2023/2024 in line with legislative requirements as overseen by the Health and Safety Governance Group.

1.2 The paper also summarises the prevailing legislative framework within which Health and Safety concerns are managed and addressed and outlines the local governance arrangements that underpin Health and Safety management within the Trust. The paper also includes information relating to activities undertaken by the Health and Safety Governance Group and its sub-groups with respect to:

- Asbestos
- Confined spaces
- Fire safety
- Health and safety training provision
- Manual handling and back care
- *Medical gas safety
- Occupational Health and Wellbeing
- Radiation safety
- Operational health and safety management for Estates, including capital projects.
- Risk management
- Security safety
- Waste safety
- Water safety
- Working at height

**Managed through Medical Gases Committee which would refer to Health and Safety Governance group any specific Health and Safety requirements for example staff exposure to Entonox.*

1.3 The Health and Safety at Work Act 1974 provides a legislative framework to promote, stimulate and encourage excellent Health and Safety at work standards. Delegated responsibility through the Chief Executive Officer is with the Chief Nursing Officer to oversee systems that ensure all staff and ancillary contractors, patients and visitors, work in a safe and compliant manner to protect both themselves and other service users from significant or avoidable harm.

1.4 In order to meet the requirements of the Act, the employer must demonstrate that there are safe operations and systems of work, safe access and egress, safe use, handling and storage of dangerous and hazardous chemicals and substances, adequate and appropriate health and safety training and adequate and appropriate welfare provisions.

1.5 In addition, the Management of Health and Safety at Work Regulations 1999 requires employers to make 'assessments of risks' and to ensure that there is effective planning, control, monitoring and review of the subsequent preventive and protective measures. The management of Health and Safety is identified in Health and Safety Executive (HSE) guidance HSG 65 which provides a framework for managing health and safety.

2. Discussion

2.1 Health and Safety Governance Group and Management Structure

2.1.1 The Trust has a Health and Safety Governance Group to plan, manage and monitor organisational compliance with statutory Health and Safety requirements and specific NHS duties. In this way, compliance with external organisational requirements such as the HSE, NHS Resolution (formerly the NHSLA), Department of Health, Care Quality Commission (CQC) etc. are managed.

2.1.2 The Health and Safety Governance Group is co-chaired by the Associate Director of Safety and Learning and the Director of Estates and Facilities on behalf of the Chief Nursing Officer and meets six times a year. The Group reports into the Trust Safety and Quality Committee which in turn reports to the Trust Board.

2.1.3 The Trust has an appointed Health and Safety Manager who is the designated Trust competent person with the necessary qualifications as defined in the requirements of the "Management of Health and Safety at Work Regulations." In October 2024, a new risk (Risk ID 2075) was identified, highlighting the vulnerability of relying on a single person within the Health and Safety Governance Team. The team currently consists of one Band 7 substantive lead and a Band 3 administrative staff member. Although the Health and Safety Manager is supported by subject matter experts across the Trust, the long-term absence of the substantive lead has exposed operational fragility. While a temporary Band 7 member has been appointed in November 2024, the ongoing reliance on a single Band 7 role continues to pose risks to the timely delivery of critical health and safety functions, including regulatory compliance, risk monitoring, and governance oversight, potentially leading to breaches. To address these concerns, a benchmarking exercise is underway to compare Health and Safety Governance practices across other Trusts, with the aim of identifying sustainable solutions. Although interim arrangements are mitigating immediate risks, the continued dependence on a single lead emphasises the need for a more resilient structure to ensure ongoing compliance and effective governance.

2.1.4 The Health and Safety Governance Group is tasked with monitoring the development, implementation, audit and delivery of Health and Safety organisational management throughout all working aspects of the Trust's diverse activities.

2.1.5 Table 1 in Appendix 1 gives an overview of the groups that report into the Health and Safety Governance Group**.** Each group oversees ratification of associated policies with chair's reports from each meeting submitted to the Health and Safety Governance Group for review.

2.1.6 The main areas of concern from the Health and Safety Governance Group are related to slips, trips and falls, sharps, waste management and medical device decontamination. Actions are in place to address the issues identified.

2.2 Compliance with legislation

2.2.1 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 general public. The requirements of this Act are covered by The Management of Health and Safety at Work Regulations 1999 that state an employer must identify the risks that employees, contractors, and members of the public may face and take steps to control or mitigate those risks through a formal risk assessment process.

2.2.2 The Trusts Estates and Facilities Department are also governed by Health Technical Memoranda (HTMs) which give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

2.2.3 To ensure the trust complies with its statutory duties under The Health and Safety at Work Act 1974 the trusts Health and Safety Governance Group is tasked with monitoring and managing compliance. The Trusts Health and Safety Governance Team and the Estates and Facilities Department have systems and processes in place to fulfil this function.

2.2.4 Table 2 in Appendix 1 gives an overview of compliance with key Health and Safety legislation.

2.3 Risk Management and Risk Reporting

2.3.1 The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999.

2.3.2 To support the management of risks, the Trust has a Risk Management Strategy and a Risk Management Policy in place. This is supported by a general risk assessment template for reportable hazards and associated risks in line with HSE guidance and is mainly used for the management of local hazards e.g. hazards associated with moving and handling and violence and aggression risks, staff exposure to radiation or radioactive materials under Ionising Radiation Regulations IRR17, exposure to asbestos, exposure to dangerous chemicals or toxic substances or diseases (e.g. Covid-19 or Tuberculosis).

2.3.3 These risk assessments are overseen and managed at local level by divisions and directorates managers and are reviewed in accordance with their risk rating with advice and guidance from the Health and Safety Manager as required. All risks deemed appropriate by departmental, speciality and divisional leads are fed into the Trust's main risk register to enable corporate planning, the setting of objectives and the establishment of business plans. At the end of September 2024, there were 438 active risks on the Trusts risk register from both clinical and non-clinical identified hazards. See Section 6 for a summary of themes of risks identified on the Risk Register related to Health and Safety.

2.3.4 Alongside locally managed risk assessments, specialist estates staff and contractors complete required risk assessments for the maintenance and operation of the estate such as asbestos, lifts, waste, ventilation, central medical gases provision and water. With this, the Director of Estates and Facilities recommends the appointment of authorising engineers (AEs) and appointed persons (APs) who provide independent expert assurance to the Trust through advice, direction, specialist training, risk assessment and audit, submitting corrective action plans to the estates departments subgroups and capital projects programme. They provide an annual audit of the delivery of the estates and facilities works in relation to the area of appointment. These audits are submitted to the Director of Estates and Facilities and onwards to relevant sub-groups, such as the water safety group, the decontamination committee, and medical gases safety group.

2.3.5 Additionally, these specialists, independently witness and test the installation and operation of systems such as fire alarms, electrical substations providing assurance on the compliance of contractors' work to NHS and Trust specific requirements. By working in this way, side by side with the Trust appointed persons, who are key members of the estates team that have attended specialist training programmes, the Trust is able to ensure that legal requirements are met, and that best practice is followed.

2.4 Policy, Standards and Documentation

2.4.1 The Trust remains aligned to the HSE Managing for Health and Safety (HSG65) 2013 and all policies relating to health and safety are reviewed in line with this standard. The Clinical Governance Team monitors policies and procedures on behalf of the organisation to ensure they are reviewed every three years as a minimum or as defined within individual documents.

2.4.2 The Trust uses a document management system, Heritage, which is available and accessible to all Trust employees. The system is held on the Trust Intranet and is maintained by Clinical Governance Team and Library Services.

2.5 Health and Safety Incident Analysis

2.5.1 Incident reporting is fundamental to the Trust being able to identify, analyse and address its risk areas.

2.5.2 Table 3 in Appendix 1 presents the Health and Safety incident reporting profiles for 2022, 2023, and 2024 (up to the end of September). It is important to note that the analysis excludes incidents affecting patients, as these are classified as clinical incidents managed under patient safety. Additionally, incidents related to infection prevention and control are not included, as they fall under the clinical safety portfolio. It should also be noted that a full year of data for 2024 is needed to make meaningful comparisons with previous years.

2.5.3 Overall, the majority of Health and Safety Incidents have resulted in No Harm or Low Harm (97.9% in 2022, 98% in 2023 and 97.1% in 2024 to the end of September 2024). There were no Health and Safety incidents reported with a harm level of Death, however there were 2 incidents of Severe harm reported in 2022 and 2023 and 3 incidents of Severe harm reported in 2024 (up to the end of September). In 2022, there was 1 Severe harm incident related to Manual Handling of equipment or machinery and 1 Severe harm incident related to physical assault by a visitor. In 2023, there was 1 Severe harm incident related to Manual Handling of equipment or machinery and 1 Severe harm incident related to Slip, Trip or Fall on the same level. In 2024 to September 2024, there is 1 Severe harm incident related to a staff member trapping a hand in a bed rail, 1 Severe harm incident related to Slip, Trip or Fall on the same level and 1 Severe harm incident related to an injury sustained whilst moving/carrying machinery/equipment.

2.5.4 Across the years, the highest reporting incident type is “Insufficient staff or workplace stress/demand”. However, from 2022 to 2023, there was a reduction in the number of incidents reported in this category suggesting improvements to staffing levels. Despite this, the reporting process for workplace stress/demand continues to be mis-interpreted. Often, staff either report the incident that has caused the stress and not the outcome or report insufficient staff as a workplace stress/demand instead of insufficient staffing. A better indicator of workplace stress/demand is often staff survey data, sickness data and the number of referrals into Occupational Health or Psychological Wellbeing in conjunction with incident data. The Divisional Governance and Risk Team, Health and Safety Manager, Associate Director of Workforce and Divisional Governance professionals are actively reviewing the way this type of incident is being reported so that the Trust is provided with a more precise representation of the problem, and it can be addressed through various services provided by Occupational Health. In the meantime, the Health and Safety Governance Group continue to receive information on Occupational Health and Psychological Wellbeing services to triangulate any themes. This has highlighted waiting times for Psychological Wellbeing service have deteriorated over the last few months and is a significant risk. An additional clinical psychologist is required to address the gap between capacity and demand, however there is no further funding available. In the meantime, an individual stress risk assessment tool is in place, based around the HSE Management Standards and a revised approach to team stress risk assessment is being developed.

2.5.5 Across the years, the second highest reported incident type is “Violence and aggression from patient or visitor” with a significant increase in the number of incidents reported in this category from 2022 to 2023. This figure remains high in 2024 to end of September 2024 indicating that violence and aggression towards staff by patients or visitors remains a risk. A number of papers have been presented to Workforce Committee which provide an update on a range of workstreams with key areas of progress including listening to colleagues in areas most affected, adopting a continuous improvement approach through the initiation of a Violence and Aggression Big Room, implementation of a Zero Tolerance Toolkit and establishment of a Sexual Safety Working Group. Progress with this work continues to be monitored by the Workforce Committee with a 3-year Violence Prevention and Reduction Strategy also in place.

2.5.6 Other incident types that have received increased focus include “Lack of Ventilation”, “Staff smoking on hospital grounds, Exposure to extreme temperature”, “Contact with sharps”, “Injured during Manual Handling”.

- To support the maintenance and routine testing of ventilation systems the Trust has appointed an authorising engineer. There is also a local inspection and service contract, controlled by the mains laboratories for all local exhaust ventilation systems that are used in clinical areas. This covers all fume cabinets and air handling systems and ensures that they are checked annually.
- In response to the increase in staff smoking incidents, discussions are ongoing with Health and Safety representatives in various forums with new protocols in place to support management of incidents related to staff smoking on hospital grounds.
- Challenges remain with extreme temperatures due to the Trust’s aging estate until the New Hospital build is in place. Whilst these are mitigated through various methods, the residual cause will not be addressed fully until the new Hospital is built.
- The main reason for sharps related incidents is due to incorrect disposal of sharps including sharps containers in the wrong waste stream and loose sharps and needles being found in domestic waste. The Safer Sharps Group continues to meet bi-monthly to review incidents with the Health and Safety Manager, Waste Minimisation Officer and Portering Manager actively working with wards and departments in an attempt to reduce these incidents.
- Medical device decontamination continues to be an area of focus with a number of different approaches being worked on to raise the profile of the reasons of why this is important and how to prevent this from occurring including production of a SOP and training.
- Mandatory moving and handling training continues to be provided as an e-learning package. Since August 2022, and the lifting of Covid-19 restrictions, face to face has started to be reintroduced for all new starters, bank staff and clinical established staff. It is expected that the availability of face to face manual handling training will start to demonstrate a notable impact in reducing manual handling incidents.

2.5.7 From January to September 2024, there has been an increase in incidents related to "Unplanned Disruptions to Infrastructure (Electricity, Gas, Telephone, and Water)." These disruptions may be connected to the ageing infrastructure and the current financial situation. Further analysis is underway to gain a deeper understanding of the underlying causes, and the findings will be addressed through the Health and Safety Governance Group.

2.5.8 Incident types seeing a noticeable decreasing trend in reporting since 2022 are “Pest Infestation” “Actual exposure to/contact with body fluids/bloods” and “Incorrectly disposed waste”.

2.6 Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reporting analysis

2.6.1 RIDDOR requires the Trust to report work-related incidents to the HSE in certain circumstances. Incidents are only reportable if they arise ‘out of or in connection with’ work but that can include incidents involving visitors, patients, and contractors in our workplaces. Depending on the severity and nature of the injury, and indeed the party affected, the Trust has a legal duty to report this data to the HSE.

2.6.2 This reporting process is undertaken by the Health and Safety Manager with reportable staff incidents divided into five categories:

- The death of any member of staff whilst at work
- A specified injury to a member of staff due to a work activity.
- A dangerous occurrence
- Staff contracting an occupational disease.

- An incident relating to flammable gases or gas fittings.

2.6.3 Table 4 in Appendix 1 details the number and type of incidents reported under RIDDOR in 2022, 2023 and 2024 (up to the end of September 2024).

2.6.4 The highest RIDDOR reported incident type remains "slip, stumble or fall," however there was a 50% decrease in the number of incidents reported between 2022 and 2023. It should be noted that a full year of data for 2024 is needed to make meaningful comparisons with previous years.

2.6.5 Full investigations are completed in all cases and the learning is built back into the relevant processes and procedures. To date, for 2023 & 2024 to date there has been no requests for further action to be taken from the HSE.

2.7 Health and Safety Training

2.7.1 As part of core skills, there are a number of elements of training relevant in relation to Health and Safety for all staff to complete. Compliance with these is monitored at individual ward/departmental level, divisional level and at Workforce Committee.

2.7.2 Elements of core skills related to Health and Safety are listed below, with a summary of organisational wide compliance at the end of August 2024.

- Health, Safety and Welfare 96.4%
- Fire Safety 93.7%
- Infection Prevention and Control (Level 1) 95.5%
- Infection Prevention and Control (Level 2) 91.4%
- Moving & Handling (Level 1) 87.7%
- Moving & Handling (Level 2) 88.6%
- Conflict resolution training 92.6%

2.7.3 The Fire Safety Team are currently collaborating with the Education and Training Team to address changes in Fire Safety legislation, which now requires all training to include a practical component. While e-learning can supplement the training, it cannot be the sole method of delivery. An options appraisal has been prepared and will be considered in an upcoming Health and Safety Governance Group.

2.7.4 The Trust also has a Leadership Responsibilities in Health and Safety module available. The target audiences for this is being revisited with the education team developing plans to build compliance into regular monthly reporting.

2.7.5 Other training related to Health and Safety is available but is role-specific e.g. breakaway techniques. In addition, managers and nominated individuals who attend the Health and Safety Governance Group are encouraged to undertake an accredited Institute of Health and Safety Awareness training with 15 members of staff having completed this training in August 2022 and 15 in February 2023. There are also 3 members of staff currently undertaking the National Examination Board in Occupational Safety and Health (NEBOSH) course enhancing their Health and Safety knowledge and understanding.

2.7.6 To strengthen understanding of roles and responsibilities in relation to Health and Safety, a dedicated training session on Health and Safety requirements was delivered to the Board of Directors during the Board Development Day in July 2024, improving the Board's understanding of key responsibilities and legislative obligations.

2.8 Audit and Monitoring

2.8.1 The Health and Safety Department undertake a number of proactive and reactive inspections and audits throughout the year to manage and reduce risk. These include:

- Environmental safety inspections – The Health and Safety support staff undertake inspections and any identified issues would be escalated accordingly. Minor issues are rectified at the time of the inspection.
- Monthly external and internal site inspections – Management of roads, footpaths and internal public areas continues, and is reported to the Senior Estates Manager. Regular proactive safety reports of the grounds and internal areas have highlighted a number of potentially hazardous situations receive appropriate attention through expenditure of capital funds as appropriate.
- Monthly environmental/building inspections - These are carried out in clinical areas by the Health and Safety Team, the results of these are reported internally via Estates and Facilities key staff.

2.8.2 A number of elements of Health and Safety are tested as part of the Safety Triangulation Accreditation Review (STAR).

2.8.2.1 A summary of key learning has been identified and relates to the following:

- Equipment is fit for purpose with testing stickers and serviced – Latest compliance (STAR accreditation visit data) is 90.3%. medical engineering report on planned preventative maintenance via the divisional always safety first forums.
- Fire exits are clear of obstruction – Latest compliance (STAR accreditation visit data) is 90.3%. Fire exits are occasionally blocked by linen cages for soiled linen bags due to issues with the linen chutes in the tower block. Although the linen chute is now repaired challenges remain with chute breakdowns, screens, trollies or other equipment blocking fire exits due to limited storage around the wards/departments.
- Oxygen and suction is available and is in working order with kit ready for use – Latest compliance (STAR accreditation visit data) is 83.9%. Themes include variation in use of the oxygen/suction checklists and occasional delays with ordering suction canisters or vacuum pumps.
- Sharps waste is appropriate and less than ¾ full with no evidence of gloves or dressings. There are no protruding sharps, and the temporary closure mechanism is in place when not in use. The bin is not stored at floor level - Latest compliance (STAR monthly reviews) is 86.67%. Overfull sharps bins on occasion or more than ¾ full which increases the risk of sharps injuries.
- Food in both patient and staff fridges are labelled appropriately - Latest compliance (STAR accreditation visit data) is 91.8% - Staff food not always labelled, missing checks and some out of date items on occasions. A learning bulletin was developed by the quality assurance team and shared via divisional always safety first forums regarding sandwiches and listeria risk following an environmental health inspection.
- The nurse call systems are within the patient's reach and nurses respond to the call bells in a timely way - Latest compliance (STAR accreditation visit data) is 93.4%. Occasional issues with call bell supply and awaiting call bell replacements with a number of related risks on the risk register.

2.8.2.2 Areas of concern include:

- Ligature risks – pull cords. Recent learning from STAR assessments highlights that staff are not consistently aware of the required standards for bathroom light pull cords and call bell cords. A review of the ligature policy revealed areas where clarity is needed regarding these standards, particularly in relation to identified risks in clinical and communal areas. Concerns include the replacement of pull cords and inconsistent adherence to standards. These issues have been escalated to the Corporate Governance Team, the Safety and Quality Divisional Leadership Team, and Estates and Facilities

Management. Progress is being actively monitored through the Health and Safety Governance Group and tracked as part of the divisional risk register actions.

2.8.2.3 Areas of good practice include:

- Mandatory training (including moving and handling) has become one of the 5 mandated critical standards assessed during the STAR accreditation process, effective from July 2024.
- Themes and learnings from STAR, including environmental issues such as damaged flooring or items awaiting repair, are reported monthly in the STAR report. This report is shared with the NMAHP Board, Divisional "Always Safety First" meetings, and the Estates and Facilities Partnership Board. A recurring issue highlighted is the poor condition of flooring, often poorly taped and awaiting replacement, which has now been escalated and included in the STAR monthly review and reporting.

2.8.2.4 Overall, the STAR audits have identified some Health and Safety risks and challenges in relation to the general environment. Due to the ageing estate, there is poor flooring and evidence of the environment in poor state of repair. This may lead to an increasing risk of falls and/or infection. Despite this, there is a good reporting culture from staff who generally report any repairs and any equipment out of service dates with the aim of getting these rectified. Though, there are some areas, such as Emergency Department, Critical Care and Theatres where it can be challenging to report and keep track of issues and equipment reported due to their footprints and the number of equipment required in these areas.

2.8.2.5 Learning from STAR is included within the STAR report which is shared with Estates and facilities Partnership Board with Quality Assurance Team support for any escalation as required. Further work is ongoing to further strengthen the learning and communication of Health and Safety themes identified through learning from incidents and audits across the wider organisation.

2.9 DSE Assessments

2.9.1 The Display Screen Equipment (DSE) assessment is an important part of the Trust's efforts to maintain a safe and healthy working environment. It ensures that workstations are set up ergonomically to prevent health issues such as musculoskeletal disorders and eye strain. Employees complete an online self-assessment to review their workstation, and if any issues are identified, they are referred for a one-on-one formal assessment with a qualified DSE assessor

2.9.2 DSE assessments have been rolled out across the Corporate and Pathology Divisions, and the process is being refined to improve efficiency. The self-assessment will be split into sections for different types of equipment, such as laptops, to reduce unnecessary referrals. While there are costs associated with assessor training and potential equipment adjustments, the ongoing assessment process is crucial for ensuring workplace safety, compliance with regulations, and employee well-being.

2.10 Notable external visits

2.10.1 Table 5 in Appendix 1 gives a summary of notable visits that relate to Health and Safety in the last 12 months.

3. Summary and Next Steps

3.1 The paper provides a summary of Health and Safety activity including that of the Health and Safety Governance Group which continues to be strengthened and reinforced through wide engagement with staff, patients and departments operating throughout the Trust to stakeholders from external regulators and organisations and trade union representative.

3.2 Despite internal and external assurance in several areas, significant challenges persist. These include delivering the Health and Safety agenda amidst long term sickness of the Health and Safety Governance Manager, financial constraints, an ageing estate, increasing staff workplace stress/demands, and ageing equipment.

3.3 To address ongoing challenges, the Associate Director of Safety and Learning is working with Estates and Facilities colleagues to revisit the Health and Safety Single Improvement Plan. Central to this initiative is the development of a Health and Safety Dashboard to enhance governance arrangements and provide actionable insights for forward planning. While this tool is intended to support the Trust in maintaining compliance with legislative requirements while operating within financial constraints, it is important to note that its development will require time and careful planning to ensure its effectiveness and integration into existing processes.

4. Financial implications

4.1 Under the Health and Safety and Nuclear Fees Regulation 2022, the HSE will recover costs for the work undertaken when managing certain contraventions of Health and Safety Law. These contraventions are known as “material breaches.” The cost recovery is known as “Fee for Intervention (FFI)”

4.2 There are a number of financial implications in mitigating a number of Health and Safety related risks, particularly whilst waiting for the development of the New Hospital.

4.3 As highlighted throughout the paper, financial constraints are impacting the ability to fully deliver the Health and Safety agenda, limiting resources and capacity for essential improvements, staffing, and infrastructure development required to meet regulatory and operational requirements.

5. Legal implications

5.1 As outlined in Section 2.2, 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 general public. Section 2.2 provides further information on compliance with relevant Health and Safety legislation.

6. Risks

6.1 There are a number of risks related to Health and Safety on the Trust’s Risk Register which may lead to non-compliance with legislation and risk to Health, Safety and Welfare of employees, as well as others on the Trust’s premises. These risks relate to a variety of reasons including food contamination, ventilation issues, fire alarms not working, extreme temperatures, poor lighting, water safety issues, degradation of windows including restrictors, decontamination, electrical issues, road surface issues, risk of exposure to ionising radiation, ligature risks, violence and aggression, moving and handling issues, physical environment challenges e.g. leaks and ageing environment and equipment.

6.2 All risks are managed in accordance with the trusts 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.

6.3 In October 2024, Risk ID 2075 was identified, highlighting operational fragility due to reliance on a single Band 7 substantive lead within the Health and Safety Governance Team. Despite temporary measures to address immediate gaps, this dependency poses risks to regulatory compliance, risk monitoring, and governance oversight. A benchmarking exercise is underway to compare Health and Safety Governance provisions across

Trusts in Lancashire and South Cumbria, with the goal of identifying sustainable strategies to enhance resilience and ensure governance continuity.

6.4 Further information on risk management and reporting can be found in Section 2.3.

7. Impact on stakeholders

7.1 The Health and Safety at Work Act 1974 legislation was introduced to apply broad duties and best practice in regard to the Health and Safety of organisations 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 and Physical health and Safety governance will ensure the trust delivers its regulatory duties in line with The Health and Safety at Work Act 1974.

8. Recommendations

It is recommended that the Board of Directors:

i. Note the contents of the report and that the report has been reviewed and scrutinised at Safety and Quality committee, confirm it is assured of the actions being undertaken to mitigate Health and Safety risks, despite ongoing challenges.
ii. Note and endorse the review of the Health and Safety Single Improvement Plan and the development of a Health and Safety Dashboard as key initiatives to enhance governance arrangements across the organisation.

Appendix 1 – Tables and Figures

Table 1 gives an overview of the groups that report into the Health and Safety Governance Group

Group	Description	Chair	Frequency of meeting
Asbestos	Management and monitoring of safe work and overseeing the implementation of the Asbestos Management Plan	Senior Buildings Manager RPH	Bi-monthly
Water safety	Management and monitoring the effective implementation and management of the Trust's Water Safety Plan and water services are managed according to the National Guidance on Legionella.	Senior Engineering Manager	Bi-monthly
Medical devices	Management and monitoring all medical devices ensuring safe procurement, usage, maintenance user training.	Medical Engineering Manager	Bi-monthly
Decontamination	Provide assurance at the operational level of the decontamination environment and that the processes within it are safe and effective.	Decontamination Manger	Bi-monthly
Integrated Partnership	To develop strategies that supports the maintenance and continual improvement of the patient environment.	Matron Infection Prevention Control	Monthly
Radiation Protection and Medical Exposures Committee	Monitor and manage all aspect of radiation protection in line with Ionising Radiations Regulations 2017 (IRR17), Ionising Radiation (Medical Exposures) Regulations 2017 (IRMER17) and Environmental Permitting (England and Wales) Regulations 2016 (EPR16)	Head of Radiotherapy Physics – Consultant Clinical Scientist Trust Radiation Protection Lead	Quarterly
Safer Sharps Group	Monitor and effect solutions to sharps related issues arising.	Health and Safety Manager	Bi-monthly
Waste Management Group	Provides a forum for the discussion of strategic waste related issues, and implementation of relevant legislation and good practice and procedures.	Senior Buildings Manager	Monthly
Joint Consultative Committee	To comply with the requirement to consult staff side representatives.	Strategy Workforce & Education Director	Bi-monthly

Table 2 gives an overview of compliance with key Health and Safety legislation

Governance Health and Safety Compliance	
Legislation	**Actions in place to support compliance with legislation**
Management of Health and Safety at Work 1999	• Health and Safety Policy in place and up to date. • Competent persons in place for Health and Safety. • Health and Safety Governance Group established to consider all aspects of health and safety. This also helps to generate targeted audits for aspects of health and safety. • Sub-groups provide chairs reports to this meeting. • Risk assessment and risk register process established. • Senior management training in health and safety for all band 6's and above. • General Health and Safety training via E-learning.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	• Reporting system established. • Investigation process in place for all reportable incidents. • Bi-monthly report to Health and Safety Governance group. • Close links with the legal team
Display Screen Equipment Regulations (DSE)1992 amended 2002)	• To ensure staff have display screen equipment assessment an E-learning package for safe use of display screen equipment has been developed • Work is underway to ensure all relevant staff complete the E-learning package. • Work is also underway to ensure sufficient trained DSE assessors in place if additional support needs are identified for staff,
Control of Substances Hazardous to Health (COSHH)	• Sypol COSHH data bases established and available to all relevant staff. • Authorised chemical disposal route established working closely with waste minimisation. • Annual chemical audit in place. • Personal protective audits carried out in accordance with the COSHH regulations. • Dangerous Goods Safety audit undertaken by specialist contractor. • At the beginning of 2023, in an attempt to be proactive, health and safety have been working with the Occupational Health doctors to introduce an annual health surveillance form that can be completed locally. A trial of the form was completed with all staff working in the labs at Royal Preston Hospital with positive outcomes with further roll out in 2024.
Ionising Radiations Regulations (IRR) 2017	• Radiation Protection and Medical Exposure Group in place • Personal dosimetry monitoring and annual medical surveillance for staff working with ionising radiations. The Trust is responsible for supplying personal dosimeters to all of LTHTR staff that work with radiation as appropriate. Christies Medical Physics and Engineering (CMPE) provide advice on the level of dosimetry required. The dosimeters are analysed by UKHSA who maintain a database of results which is checked locally by the radiation protection Supervisors for any discrepancies. This is a legal requirement. Doses throughout 2023 were within acceptable levels without significant variations from previous years. • Currently the Trust has a number of staff (all staff in Nuclear Medicine and Radiopharmacy and 2 members of staff in Interventional Radiology) that have been classified under the Ionising Radiation Regulations (IRR17 regulation 21). This means that they have the potential to receive an effective (whole body dose) in excess of 6mSV/yr of radiation or more than three tenths of the dose limited to the extremities. All staff have been informed by letter and arrangements have been made to allow for appropriate health surveillance to be carried out on annual basis. CMPE review the dosimetry at the beginning of each year to determine whether the classification will remain. • Arrangements in place for the recording of the secure and safe transportation of stored radioactive materials and radioactive waste • CMPE have been appointed as radiation protection advisors to the Trust, providing expert advice on new imaging designs and existing facilities. • Each modality has its own radiation protection supervisor(s). • CMPE have devised a programme of regulatory audits in the various departments to check compliance. They provide reports for discussion at the Radiation Protection and Equipment Liaison Group meeting that meet monthly and the Radiation Protection and Medical

	Exposure Committee (RPMEC) which meets quarterly. The chairs report from RPMEC reports into the Health and Safety Governance Group meeting.
Part II of UK Medical Devices Regulations 2002 (as amended) on medical devices	• Policy for the Management of Medical Devices in place. • Medical Devices Management Group in place with reports to Health and Safety Governance Group. • Medical Engineering Operations Manager. • Also see table 5 for external assurances.
HTM 05-01 **Managing Healthcare Fire Safety**	• Fire Safety Policy in place. • There is a Fire Safety Management System in place. • There is a Fire Safety Manager appointed. • Fire Safety Training in place for all staff. • Fire Safety Reports to the Health and Safety Governance Group. • Fire Risk assessments in place for all areas. • Fire Drills in place. • Currently a focus on role specific training in Fire Safety through Health and Safety Governance Group.

Physical Risk Health and Safety compliance Legislation and Supporting Evidence Overview

The Estates and Facilities Department have a statutory compliance tracker spreadsheet for all relevant legislation and another for all HTM's. There are Key Performance Indicators (KPI's) for each element of the legislation or HTM and these are reviewed and scored. There is an associated risk assessment and where compliance is not being delivered an action plan with associated timescales is formulated. Any red KPI's trigger an estates and facilities risk to be entered onto the trusts risk register and managed in accordance with the Trust Risk Management Policy. The Trusts Health and Safety Governance Team monitor, audit and review the effectiveness of organisational Health and Safety management arrangements.

Legislation	Supporting Evidence
Lifting Operations and Lifting Equipment Regulations **Heath Technical Memorandums** • **HTM 00** • **HTM 08-02** **Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) L113** **British Standards 7255:2012** • **BS 8210:2012** • **BS 9999:2017** • **BS 5655-10.1.1:1995**	• System of checks for all lifting equipment established with Arjo and Alliance, the Trusts authorising engineers.
Control of Asbestos Regulations 2012	• Annual Management asbestos survey completed. • Funding allocated for any actions generated. • Refurbishment and Demolition surveys carried out for major projects as required. • Active Asbestos Management Plan established. • Operational Asbestos Group established. • Reports into the Health and Safety Governance Group Meeting.
Electricity at Work Regulations 1989	• Authorising Engineers (AE) trained and available to completed general checks.

BS7671 **HTM 06**	
HTM 02-01 **Medical Gas Pipeline Systems (MGPS)**	• MGPS operational policy in place. • Authorising Engineers trained and available to completed general checks.
Management Regulations and Confined Spaces Regulations 1997	• Areas within the Trust are assessed to identify if they present confined spaces hazards. • There are procedures for risk assessments to be carried out prior to entry.
Work at Heights Regulations 2005	• Work at Heights and Ladder Safety policy includes pre use and annual checks including the use of Ladder Safety Checklists and the need to carry out site specific risk assessments for higher risks including developing emergency plans.
Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises Part B, Operational management and performance verification	• Ventilation Policy in place. • There is an appointed Authorising Engineer and they suitably trained. • Up-to-date drawings for ventilation systems available. • Permit-to-work system in place.
Safe Water in Healthcare Premises **HTM 04-01**	• Water Hygiene Policy in place. • Water Safety Plan in place. • Authorising Engineer for Water Safety. • Trust Water Safety Group (WSG).

Table 3 Details Health and Safety incident reporting profiles for 2022, 2023 and 2024 (to end of September 2024) *

Incident Type		2022	2023	2024 (to end Sept)*	Grand Total
Accidents	Burn or Scald	18	24	18	60
	Collision with an object (e.g. equipment, furniture and/or fittings)	46	44	34	124
	Contact with Electricity	3	1	0	4
	Contact with Sharps	160	233	161	554
	Slips, Trips, Falls	162	164	107	436
	Hit by a moving vehicle/moving or falling object	38	28	30	96
	Injured during Manual Handling (equipment, machinery or patient)	71	93	69	233
	Unexplained injury	36	22	30	88
	Trap injury	22	29	21	72
	Choking/inhalation of food/medication/fluids	5	5	6	16
Staff Behaviour	Staff smoking on hospital grounds	14	28	9	51
Violence & Aggression	Violence & Aggression by patient or visitor	984	1211	909	3104
	Violence & Aggression by staff	185	149	131	465
Fire Incidents	Fire Incidents (including actual, false alarm and fire hazards)	354	326	198	878
Environment	Actual exposure to chemical/biological agent (e.g. asbestos)	22	22	14	58
	Actual exposure to/contact with body fluids/bloods	187	98	50	335
	Exposure to excessive noise/light	6	10	6	22
	Exposure to extreme temperature (hot or cold)	137	215	138	490
	Exposure to smoke	12	14	4	30
	Exposure to unhygienic environment	113	94	73	280
	Exposure to unsafe buildings/infrastructure	60	70	32	162
	Exposure to unsafe equipment/machinery	55	47	30	132

	Exposure to water/damp	32	30	17	79
	Flood	4	6	5	15
	Gas Leak	0	1	0	1
	Incorrectly disposed sharp	47	30	24	101
	Incorrectly disposed waste	51	36	17	104
	Lack of ventilation	4	9	22	35
	Legionella	2	2	2	6
	Pest Infestation	28	14	11	53
	Potential Exposure to chemical/biological agent (e.g. asbestos)	12	12	11	35
	Pseudomonas	0	1	0	1
	Unplanned Disruption to Infrastructure (Electricity, Gas, Telephone and Water)	11	16	31	58
Staffing	Insufficient staff or Workplace Stress/Demand	2112	1992	1445	5549
Security	Security incidents (breaking and entering, public order, vandalism, unsecure estate)	111	96	84	291
	Restraint incident	34	32	18	84
Grand Total		5138	5204	3757	14099

** It should be noted however that the analysis of Health and Safety incident data within this report excludes incidents affecting patients, as these would be considered clinical incidents managed from a patient safety perspective. It also excludes incidents regarding infection prevention and control, as this is considered within the clinical safety portfolio. It should also be noted that a full year of data for 2024 is needed to make meaningful comparisons with previous years.*

Table 4 Details the number and type of incidents reported under RIDDOR in 2023 and 2024 (up to end of September 2024)*

RIDDOR incidents reported by type	2022	2023	2024 (up to end of Sept)*	Grand Total
Slip, stumble or fall	16	8	8	16
Other - cause not listed	12	7	6	13
Pushing or pulling	4	3	1	4
Lifting, carrying, standing up	1	5	2	7
Twisting or turning		2	1	3
Shock, fright, violence, aggression		1		1
Overflow, leak, vaporisation or emission of liquid, solid or gaseous product		1	2	3
Electrical problem, explosion or fire			1	1
Loss of control of machinery, transport or equipment			1	1
Being caught or carried away by something (or by momentum)			1	1
Grand Total	33	27	23	50

**It should also be noted that a full year of data for 2024 is needed to make meaningful comparisons with previous years.*

Table 5 gives a summary of notable visits that relate to Health and Safety in the last 12 months

Lancashire Fire and Rescue Inspecting Officer Visits	- 9th October 2024, RPH Chapel, no actions. - 18th October 2024, CDH Astley Ward, fire doors seen to be wedged open. Fire manager advised staff to submit minor improvement request to fit automatic door closers. - 18th October 2024, CDH Rookwood A, escape routes compromised with pallets. Portering manager contacted, pallets removed within the hour.

12.2 REVISION TO BOARD OF DIRECTORS COMMITTEE TERMS OF REFERENCE

Decision Item | J Foote | 15:00

REFERENCES

Only PDFs are attached

12.2 - Revision of Terms of Reference - ETR and WFC - Nov 24.pdf

Board of Directors Report

Revision of Terms of Reference – Education, Training and Research and Workforce Committees

Report to:	Board of Directors	**Date:**	5 December 2024
Report of:	Director of Corporate Affairs	**Prepared by:**	J Foote
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The report sets out the rationale for a revision of the terms of reference of the Education, Training and Research (ETR) and Workforce Committees to allow for membership for the Executive Director whose portfolios cover the remit of each committee.

This will require the Board to rescind the current delegated authority given to each committee (but rarely, if ever used in the past two years).

The Board is asked to approve the revisions to the Terms of Reference of the ETR and Workforce Committees.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

1. Introduction

The report sets out proposals to revise the terms of reference (ToR) of the Education, Training and Research (ETR) Committee and the Workforce Committee to allow the respective Executive Directors who hold the portfolio for these areas to sit as full members of the committees.

2. Background

The current terms of reference of the committees of the board were last reviewed in February 2023. At that time the decision was made to allow some potential delegated authority to the committees. This in turn would lock down the membership of them to voting members only.

Subsequent changes to the Executive Team have resulted in the Executive Directors with the portfolios for education, research and workforce only being in attendance at these committees, rather than full members.

It is proposed that the remit of both the ETR and Workforce Committees are revised slightly to make them pure assurance committees with no delegated authority. This would then allow the membership to be widened to allow the Chief People Officer and the Director of Continuous Improvement and Research the ability to sit as full members of the committee, including counting towards the quoracy of the meetings.

It is not proposed that this rule is applied to other committees of the board and the requirements for these to have only voting directors as members will remain.

The ToRs were recently assessed independently by NHS England and no recommendations were made for further revision.

The revised ToR are attached as appendices 1 and 2. The only amendments made have been in connection with delegated authority and membership of non-voting directors. No amendments have been suggested for the substantive responsibilities or remit of the committees.

3. Financial implications

None.

4. Legal implications

The establishment order of the Trust only allows for five Executive Directors with full voting rights (currently the Chief Executive Officer, Chief Finance Officer, Chief Operating Officer, Chief Medical Officer, and Chief Nursing Officer). Statutory rules for Foundation Trusts only allow voting directors to sit as members of Trust committees if those committees have any authority delegated from the board.

5. Risks

There is a risk that the membership of the committees drift and tight management of this will be required by the Corporate Affairs team under the direction of the committee chair. However, the reflection of membership against portfolios should allow for a more effective discharge of responsibilities for these committees.

6. Recommendations

The Board is asked to approve the revisions to the Terms of Reference of the ETR and Workforce Committees.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
EDUCATION, TRAINING AND RESEARCH COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Education, Training and Research Committee (hereinafter referred to as "the Committee"). The Committee is a non-executive body and therefore has no executive powers.

2. PURPOSE

2.1 The purpose of the Committee is to provide strategic direction and board assurance in relation to education, training, research and innovation activity.

3. RESPONSIBILITIES

3.1 To give consideration to the strategic direction and funding plans for the Trust in relation to research, education and training and make recommendations to the Board on these matters.

3.2 To consider reports, recommendations and proposals:

- On all research and development activity in the Trust – publications, grants, etc.
- From educational and research work streams
- On national and local priorities to guide activities in relation to education and training and research and development

3.3 To receive summary reports and action plans in relation to quality assurance reports from external bodies on behalf of the Board, and to escalate any matters that may need to be brought to the attention of the Board of Directors or other assurance committee as a result thereof.

3.4 To inform the strategic and funding plans for education and training activity in line with service development.

3.5 To inform the strategic and funding plans for research and development.

3.6 To review educational performance within the operational delivery of the Trust's service, ensuring that activity complies with relevant statutory and regulatory frameworks and guidance.

3.7 To review education and training budgets, investment plans and divisional education contracts and consider whether value has been demonstrated.

4. COMPOSITION AND CONDUCT OF THE COMMITTEE

4.1 The Committee shall comprise the following membership:

— Three non-executive directors (one to Chair)
— Two executive directors (who may be voting or non-voting members of the Board)

4.2 The Committee may also invite or direct to attend such Directors and other Officers of the Trust as identified for the conduct of business of the Committee.

4.3 The Committee will be supported by the Corporate Affairs Team.

4.4 A number of work streams will support the work of the Education, Training and Research Committee in providing Board assurance around a range of activities related to the remit of the Committee, such as through the provision of annual reports and action plans.

4.5 Only members of the Committee and Company Secretary shall be entitled to attend meetings although there is an open invitation for any non-executive director to attend any or all meetings.

4.6 Members with a conflict of interest in any agenda item presented to the Committee shall declare their conflict and withdraw from discussions.

4.7 In the absence of the Chair of the Committee, the remaining members shall elect one of the other non-executive director Committee members present to Chair the meeting.

4.8 ***Quorum***: A minimum of three Committee members, two of whom should be non-executive directors.

4.9 ***Frequency of meetings***: The Committee will, as a minimum, meet six times per year.

4.10 ***Minutes***: The minutes of meetings shall be formally recorded as directed by the Director of Corporate Affairs.

5. DELEGATED AUTHORITY

5.1 The Committee is authorised by the Board to:

i. Investigate any activity within its terms of reference, including the request for additional reports and information to be submitted to the Committee;
ii. Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee; and
iii. Obtain independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5.2 For the avoidance of doubt the Committee may not approve, decide or direct in its own capacity but may only recommend to the Board the approval of any action other than as set out in 5.1 above.

6. REVIEW

6.1 The Committee shall evaluate its effectiveness and performance of the Committee on an annual basis.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
WORKFORCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Workforce Committee ("the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to:

- oversee the development and implementation of the workforce and organisational development strategy for the organisation
- review human resources policies and procedures relating to contractual or legislative changes on behalf of the Board of Directors and recommend any revisions to the Board.
- provide assurance to the Board on the development, implementation and review of the Trust's workforce and organisational development strategy and workforce plan in order to support service improvement and to meet the needs of patients, staff, regulators and commissioners
- develop strategic workforce recommendations for approval by the Board
- monitor performance of workforce metrics within any strategic or other forward plan.

2.2 The main functions of the Committee are to:

i. Contribute to the development of an effective workforce and organisational development strategy and to make appropriate recommendations to the Board for approval
ii. Receive assurance on behalf of the Board that the Trust's workforce and organisational development strategy and related policies satisfy relevant national, regional and organisational requirements.
iii. Monitor performance and the data quality of workforce information, seeking assurance on the effectiveness of the workforce performance management framework
iv. Consider the control and mitigation of workforce-related risks as identified in the Board assurance framework and provide assurance to the Board that such risks are being effectively controlled and managed
v. Obtain assurances that the Trust's workforce plan supports the development aims of the organisation through the identification of an appropriate workforce model and development plan
vi. Receive Chair reports from subgroups (as may be established from time to time) in respect of areas of identified concern, seeking assurance that robust actions have been identified to address/resolve these issues/concerns:

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Three non-executive directors (one to chair)
- Two executive directors (who may be voting or non-voting members of the board)

3.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business. Only members of the Committee shall be permitted to vote.

3.3 ***Quorum***: Three members, at least two non-executive directors and at least one executive director.

3.4 ***Frequency of meetings***: The Committee will normally meet six times a year.

3.5 ***Minutes***: The minutes of meetings shall be formally recorded as directed by the Director of Corporate Affairs.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee
iii. require additional reports to be submitted to the Committee to address any assurance issue identified

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS AND ITS COMMITTEES

5.1 The Committee will report in writing to the Board of Directors the basis for its recommendations. The Board of Directors will use that report as the basis for their decisions but would remain accountable for taking the decision. Minutes of the Board of Directors will record such decisions.

6. REVIEW

6.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis.

13. ITEMS FOR INFORMATION

13.1 REPORTS:

(a) Emergency Preparedness Resilience and Response (EPRR) Core Standards 2024-25

REFERENCES

Only PDFs are attached

13.1 - EPRR Core Standards Annual Assurance 2024-25.pdf

Board of Directors Report

Emergency Preparedness, Resilience & Response (EPRR) Core Standards Annual Assurance 2024-2025

Report to:	Board of Directors	**Date:**	5 December 2024
Report of:	Chief Operating Officer (Accountable Emergency Officer)	**Prepared by:**	S Hughes
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

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

This report details the annual self-assessment carried out for the period 2024-2025.

On delegated authority of the Trust Board the Finance and Performance Committee confirmed that the report and associated appendices, and the actions contained within, provided sufficient assurance of compliance with the EPRR Core Standards, and on 24 September 2024 approved the EPRR Core Standards Annual Assurance 2024-2025 for escalation to Lancashire and South Cumbria Integrated Care Board (ICB); the ICB will then submit a collated response for the local health economy to NHS England (Lancashire & South Cumbria).

It is recommended that:

I. The Board formally acknowledge the Trust's submission of Substantial Compliance for the EPRR Core Standards for 2024-2025, as detailed in Appendix 1. Recognising the approval granted by both the Accountable Emergency Officer and the Finance and Performance Committee, reinforcing the Trust's dedication to maintaining high standards of emergency preparedness.

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration
Finance & Performance Committee, 24 September 2024; On delegated authority of the Trust Board the Finance and Performance Committee confirmed that the report and associated appendices, and the actions contained within, provided sufficient assurance of compliance with the EPRR Core Standards, and on 24 September 2024 approved the EPRR Core Standards Annual Assurance 2024-2025 for escalation to Lancashire and South Cumbria Integrated Care Board (ICB). Risk Management Group: 20 August 2024; approved.

1. **Background/Context**

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

2. **Discussion**

   Statement of Compliance

   The attached **Appendix 1: Statement of Compliance,** details the Trusts 2024-2025 overall submission of **Substantial Compliance** for the EPRR Core Standards Annual Self-assessment; this submission was approved and signed off by the Accountable Emergency Officer on 7 August 2024.

   Appendix 1: Statement of Compliance

   Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-25

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

   Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2024-25 standards: **Substantial Compliance**.

   LTHTr Core Standards Self-Assessment

   The self-assessment against the relevant core standards, identifying the level of compliance for each standard, including supporting evidence can be found in **Appendix 2: LTHTr Core Standards for EPRR 2024**.

EPRR Action Plan
Where areas require further action, this is detailed in the attached **Appendix 2: LTHTr Core Standards for EPRR 2024** and will be reviewed in line with the organisation's governance arrangements. There are six areas requiring further action.

Deep Dive
Each year a deep dive is conducted to gain additional assurance into a specific area. This year's deep dive focussed on 'Cyber Security and IT related Incidents'. This deep dive applies to all providers of NHS funded care, including acute, community and mental health trusts.

Assurance, compliance, and evidence for the deep dive was provided by S Hughes (EPRR Manager); with details available in **Appendix 2: LTHTr Core Standards for 2024.**

We are fully compliant with six of the standards and partially compliant with five. Please note that the results of the deep dive are reported separately and **do not** contribute to the Trusts overall compliance rating.

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

3. **Financial implications**
'None'

4. **Legal implications**
'None'

5. **Risks**
'None'

6. **Impact on stakeholders**
Not applicable

7. **Recommendations**

It is recommended that:

I. The Board formally acknowledge the Trust's submission of Substantial Compliance for the EPRR Core Standards for 2024-2025, as detailed in Appendix 1. Recognising the approval granted by both the Accountable Emergency Officer and the Finance and Performance Committee, reinforcing the Trust's dedication to maintaining high standards of emergency preparedness.

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

Lancashire & South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

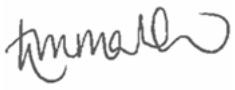
Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

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

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

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

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



Signed by the organisation's Accountable Emergency Officer

07/08/2024

Date signed

07/01/2025	07/01/2025	2025
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

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

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	3	1	0
Cooperation	4	3	1	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	11	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	56	6	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	6	5	0
Total	11	6	5	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 6: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 7: In the Action Plan tab, click on the 'Format Action Plan' button.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
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), with the Deputy Chief Operating Officer serving as their delegate when necessary. The Executive Team Portfolio includes EPRR and Business Continuity under the Chief Operating Officer's responsibilities. The EPRR Policy outlines the specific duties of the AEO. **EPRR Policy**	Fully compliant	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust has an EPRR Policy that designates the Chief Operating Officer as the Accountable Emergency Officer, responsible for: - Ensuring the Trust has a designated Emergency Planning Officer (EPRR Manager) in accordance with good practice. - Providing the Emergency Planning Officer (EPRR Manager) with the necessary resources, funds, and ensuring all staff are appropriately trained for their roles, with access to an EPRR exercise and training program. - Collaborating with the Emergency Planning Officer (EPRR Manager) to develop and maintain adequate and appropriate Emergency Preparedness and Business Continuity Management arrangements, including proper procedures for managing emergency incidents requiring Trust-level command and control. The EPRR Policy is a new, stand-alone document developed in February 2024, based on feedback from last year's NHSE check and challenge. **EPRR Policy**	Fully compliant	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	An EPRR annual summary report, including a statement of compliance and audit, is provided to the Trust Board in the form of the NHSE EPRR Annual Self-Assessment assurance documents and is available in the Board minutes. These reports include updates on training and exercises undertaken in the Trust, summaries of any business continuity, critical, or major incidents experienced, and any lessons identified, if applicable. The Trust's compliance status in relation to the latest NHSE EPRR assurance process is also presented to the Board for oversight and approval. The EPRR Manager and Head of EPRR are responsible for these board reports. **EPRR Board Report.** **Board Minutes.**	Fully compliant	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual EPRR work program aligned with current guidance, best practices, and informed by the NHSE EPRR core standards. The EPRR Committee regularly reviews and reports on the work program, especially in light of identified lessons and risks. This reporting process is detailed in the EPRR Policy. **EPRR Workplan & EPRR Policy.**	Fully compliant	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy outlines the necessary resources and roles needed to execute its functions including a description of EPRR staff. Whilst the EPRR function is currently being fully discharged, it is temporarily being supported by the capacity management administrative team. The Trust recognises that the EPRR team could be strengthened, and this will be re-assessed in the coming year. Additionally, the Trust has internal governance processes and organisational structure charts. **EPRR Policy.** **Structure Chart.**	Partially compliant	N.B. While the EPRR function is currently being discharged, the trust is at risk due to its dependence on a single individual in the role. This situation creates a single point of failure, as the entire service relies on one person. Despite the work being completed the trust cannot be considered fully compliant. To ensure robust and resilient EPRR capabilities, additional support and resources are needed to mitigate this risk and ensure continuity in case of absence or turnover of the current individual in the role.
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The Trust has clearly defined processes for capturing lessons from incidents and exercises. These are reviewed by the EPRR Committee to inform the future development of the Trust's EPRR arrangements. Lessons identified from live incidents or exercises are shared both internally and externally through incident/exercise reports. In accordance with Core Standard 3, any relevant reports are shared annually with the Board. **Core Standards Action Plan.** **EPRR Policy.** **Exercise Action Tracker.** **Plan Action Tracker.**	Fully compliant	
Domain 2 - Duty to risk assess							

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
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 and are regularly reviewed by the EPRR Manager. Additionally, these risks are reviewed by the EPRR Committee. **EPRR Risk Register** **EPRR Policy**	Fully compliant	
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust employs a robust method for reporting, monitoring, and escalating risks using the DATIX system. The EPRR Manager reviews risks monthly, and the EPRR Committee conducts quarterly reviews. EPRR risk management is also referenced in the EPRR Policy. **EPRR Risk Register.** **EPRR Policy.** **Trust Risk Management Policy.**	Fully compliant	
Domain 3 - Duty to maintain Plans							
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Plans and arrangements have been developed in collaboration with relevant stakeholders, including emergency services and health partners, aimed at enhancing joint working arrangements and ensuring comprehensive consideration of the entire patient pathway. This year, significant collaborative planning efforts were undertaken for various industrial action responses, in close partnership with the ICB and neighbouring Trusts affected by the action. Updates to plans also involved collaboration with surrounding Trusts, local Police, Fire, and Ambulance services. External stakeholders were actively engaged in consultations regarding our incident plans and CBRNe/HazMat plan. Any adjustments resulting from these consultations are meticulously documented in the Amendment History tracker within each respective plan. **Plan Action Tracker.** **Amendment History/Consultation on Plans.** **EPRR Policy Section 5.4.**	Fully compliant	
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has established robust arrangements to define and respond to Critical and Major incidents in accordance with the EPRR Framework. These arrangements are as follows: The Major Incident Response Plan has been fully reviewed and updated within the last year to ensure alignment with the latest national guidance and incorporating feedback from the NHSE check and challenge process from the previous year's core standards annual assessment, 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 validated through three separate exercises conducted in September 2024. These exercises tested the effectiveness of the plan and the preparedness of the response staff. The Tactical and Strategic training exercises used the Major Incident Response Plan to ensure response staff are well-prepared to execute the plan during actual incidents and ensured that those responsible for implementing the plan are fully aware of their roles and responsibilities during an incident. OPEL levels are monitored four times a day to assess pressures and capacity within the trust. This frequent monitoring allows for timely and appropriate responses to emerging pressures. Local Business Continuity Plans are in place and can be activated if required to maintain essential services during disruptions. These comprehensive arrangements ensure that the organisation is well-prepared to respond to critical and major incidents, maintaining continuity of care and ensuring patient safety. **Major Incident Response Plan.** **Communications Response Plan.**	Fully compliant	
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has established effective arrangements to respond to adverse weather events in accordance with current guidance and legislation. These arrangements are outlined in the trust's comprehensive Adverse Weather & Health Plan, which includes provisions for both hot and cold weather planning and response. The plan was reviewed and updated following an Amber Heat Health Alert in September 2023. Lessons identified during the enactment of the plan were evaluated, and the plan updated accordingly. An annual review was conducted in May 2024, 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	

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
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	The Trust has established comprehensive arrangements to respond to infectious disease outbreaks, including a range of diseases and High Consequence Infectious Diseases (HCIDs). The trust has developed a variety of plans and policies to address different infectious agents, ensuring a robust response framework. Specific procedures are in place for the management of Severe Acute Respiratory Infections (SARIs), such as Avian Influenza, MERS-CoV, and SARS. There are also dedicated procedures for managing patients suspected of or infected with Viral Haemorrhagic Fevers (VHFs), including Ebola. All plans and policies are readily accessible to staff via the trust intranet, ensuring that the necessary information and guidance are available when needed. These arrangements ensure that the trust is well-prepared to respond effectively to a wide range of infectious disease outbreaks, safeguarding both staff and patients. **Procedure for Management of Patients suspected of having or infected with VHF** **Procedure for Management of Severe Acute Respiratory Infections** **Outbreak Procedure**	Fully compliant	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a comprehensive Pandemic Plan to respond to new and emerging pandemics. The plan was reviewed and updated in June 2024 to incorporate the latest national guidance. The plan was included as part of a suite of plans tested during Exercise Hibbert in September 2024 and will be tabletop exercised in full in 2025. **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. The Trust has a newly developed Countermeasures plan, created in response to feedback from the NHSE check and challenge process. This plan has undergone thorough consultation both internally and externally. Our Countermeasures or Mass Countermeasures response capabilities have been recently tested through the Covid.19 pandemic, particularly in the administration of vaccines and treatments, and the response to the monkeypox outbreak (smallpox vaccine). 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. These measures ensure the Trust is well-prepared to support such deployments effectively. The Countermeasures plan was validated during Exercise Hibbert and the Strategic Commander training in September 2024. **Countermeasures Plan.**	Fully compliant	
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Trust has robust arrangements in place to respond effectively to incidents involving mass casualties. The Major Incident Response Plan has been fully reviewed and updated within the last year to ensure alignment with the latest national guidance and incorporating feedback from the NHSE check and challenge process from the previous year's core standards annual assessment, 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. The Major Incident Response Plan was validated through three separate exercises conducted in September 2024, all focused-on mass casualty scenarios. These exercises tested the effectiveness of the plan and the preparedness of the response staff to a mass casualty incident. The Tactical and Strategic training exercises used the Major Incident Response Plan to ensure response staff are 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. There is an Emergency Department Decant plan ready for use if mass casualties overwhelm the department, complemented by escalation and temporary placement plans. Additionally, the ED has procedures in place for safe patient identification using the internal Quadramed system and paper records, ensuring effective management of unidentified patients during emergencies. These measures collectively ensure the Trust is well-prepared to manage incidents with mass casualties efficiently and safely. **Major Incident Plan.** **Business Continuity Plans.** **ED Mass Casualty Decant Plan.** **Escalation Plan.** **Temporary Placement and Boarding of Patients on Inpatient Wards.**	Fully compliant	

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16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance and legislation, the organisation has established arrangements for evacuating and sheltering patients, staff, and visitors. The Evacuation and Shelter plan underwent a comprehensive review and consultation process internally and externally in April 2024, incorporating feedback from the NHSE check and challenge and aligning with updated national guidance. These measures ensure the organisation is prepared to effectively evacuate and provide shelter to all individuals during emergencies.The plan was included as part of a suite of plans tested during Exercise Hibbert in September 2024. **Evacuation and Shelter Guidance.**	Fully compliant	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance, regulation, and legislation, the organisation has established arrangements to control access and egress for patients, staff, and visitors during incidents affecting its premises and key assets. The trust maintains an overarching Lockdown/Controlled Access Plan, overseen by the Estates and Facilities division's Security Management Specialist. This plan is regularly administered, reviewed, and tested to ensure readiness. An out of hours Lockdown exercise took place on 01.12.23 at 05:00. These proactive measures ensure the organisation can effectively manage and control access and egress in various incident scenarios, safeguarding the security and safety of all individuals within its premises. **Controlled Access/Lockdown Plan.**	Fully compliant	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	In line with current guidance and legislation, the Trust has established arrangements to effectively respond to and manage "protected individuals," including Very Important Persons (VIPs), high-profile patients, and visitors to the site. The trust operates under an overarching Communications Incident Response plan specifically designed for this purpose, overseen by the Communications Team. Additionally, the LSMS (Local Security Management Specialist) ensures the implementation of robust processes within the trust's security team. These processes are activated upon notification of the presence of a high-profile patient or during high-profile events in the vicinity. Responsibility for managing such incidents is clearly outlined within the organisation's EPRR Policy and Major Incident Plans, ensuring a coordinated and secure environment for all individuals of importance within the trust's premises. **Communications Incident Response Plan.** **Management of Prisoner Patients SOP.** **Prisoners in Hospital Procedure.**	Fully compliant	
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has actively participated in and comprehends its role within multi-agency arrangements for handling excess deaths and mass fatalities, including mortuary management for rising tide and sudden onset events. The Trust has implemented a robust mortuary surge management plan designed to expand capacity during periods of heightened demand. The Mortuary team is thoroughly acquainted with both internal and external processes and arrangements. They continuously monitor onsite capacity and escalate as necessary. Effective communication is maintained between the EPRR Manager and the Mortuary Team, ensuring all are prepared to raise any concerns promptly. This coordinated approach ensures the organisation is well-prepared to manage and respond to scenarios involving excess deaths and mass fatalities, contributing effectively within the broader multi-agency framework. As this is a new guideline this will be exercised in the next 6 months. **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 mechanisms and structures in place to ensure 24/7 receipt and action of incident notifications, whether internal or external, with the capability to escalate notifications to executive levels as necessary. The EPRR Policy outlines the process, roles, and responsibilities within the Command and Control structure. Standards and expectations for on-call personnel are clearly defined within the Policy and supported by an on-call handbook and SOP, available to all on-call staff. This handbook includes detailed procedures for 24-hour alerting of managers and other key personnel. Colleagues have access to the on-call rota via the Trust intranet and can contact Switchboard at any time to connect with the on-call manager. A dedicated line at Switchboard is designated for receiving incident notifications, with a cascade process in place to ensure timely dissemination of information. Furthermore, the on-call cascade alerting process undergoes testing every 6 months as a minimum, ensuring it remains effective and responsive. Regular reviews and updates to these processes maintain readiness and resilience in managing incidents around the clock. **EPRR Policy.** **Senior Manager & Exec On Call Handbook.** **Senior Manager & Exec On call SOP.**	Fully compliant	

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21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The trust ensures trained and up-to-date staff are available 24/7 to manage escalations, make decisions, and identify key actions. Our Senior Manager, Executive on-call, and Trust Operational Officer rota facilitates this capability. These individuals have completed NHS England EPRR PHC training, aligning with National Minimum Occupational Standards. Each commander follows a specific decision-making process outlined in the EPRR policy, supported by skills-based training and exercising sessions that simulate escalation scenarios. Familiarity with Joint Emergency Services Interoperability Principles (JESIP) and the Joint Decision Model (JDM) guides their decision-making methodology. During shifts, on-call colleagues know whom to consult and inform, ensuring a collaborative approach. Maintaining accurate records and logbooks is emphasized to capture all decisions and actions effectively. Training frequency for on-call staff is regularly reviewed and updated according to the Trust's EPRR Training Needs Analysis (TNA). This comprehensive approach ensures our staff are prepared and proficient in handling escalations and critical decisions around the clock. **EPRR Policy.** **Training Needs Analysis.** **Training Records.** **On-Call Rota.** **Senior Manager & Exec On Call Handbook.** **Senior Manager & Exec On call SOP.**	Fully compliant	
Domain 5 - Training and exercising							
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The Trust conducts training aligned with a comprehensive Training Needs Analysis (TNA) to ensure staff remain current in their response roles. This process is explicitly outlined in the EPRR Policy, supported by detailed guidance in the EPRR Training & Exercising document. The TNA systematically identifies and defines the training requirements for on-call personnel and EPRR staff. The EPRR Manager maintains a central log documenting training courses and attendance, including records of exercises attended. This log serves as evidence of compliance with training and exercising requirements. The EPRR Training record effectively tracks and documents training and exercising compliance levels for all relevant staff. **EPRR Policy.** **Training Needs Analysis.** **Training Records.** **Training & Exercising Guidance.**	Fully compliant	
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	The Trust maintains an exercising and testing programme that meets minimum requirements while adhering to current guidance, ensuring incident response arrangements are safely tested without undue risk to participants or patients in our care. Our approach exceeds minimum standards with exercises conducted regularly across various scenarios: - Communication exercises occur every 6 months. - Three tabletop exercises were held in September 2024. - Live exercises included ED Lockdown, Articulated Decontamination Tent deployment, and the testing of our CBRN decontamination capabilities at RPH with the new decontamination unit. - Equipment test with an unannounced deployment of our Articulated Decontamination Tent at RPH. - Additionally, seven business continuity exercises were conducted. During episodes of industrial action, the Incident Management Team was activated with continuous command and control maintained 24/7. Training sessions throughout the year included a mass casualty tabletop exercise involving multi-agency partners, ensuring comprehensive preparedness. Lessons learned from these exercises and training sessions are systematically captured and applied to enhance future responses and update plans. Importantly, our exercises are conducted with stringent safety measures, ensuring no participants or patients in our care are exposed to unnecessary risks. The Trust also responded to a live Business Continuity incident on 19.07.24 and a Major Incident Standby on 30.07.24 both of which were followed by debriefs to capture key learning. Debrief reports have been circulated and identified actions will be monitored by the EPRR Committee to ensure the full continuous improvement cycle is completed. **Exercise Schedule.** **Exercise Reports.** **Exercise Action Tracker.** **Incident Debrief Reports.**	Fully compliant	
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	The EPRR Manager oversees a record of training and exercise attendance, ensuring that all individuals in key response roles maintain adequate training for their responsibilities, in alignment with Minimum Occupational Standards. A comprehensive Training Needs Analysis (TNA) guides the specific training requirements for on-call staff, ensuring adherence to these standards. Regular reviews of training frequency are conducted based on the EPRR TNA, ensuring that training remains current and relevant. The EPRR Training record accurately reflects and documents the compliance levels for all staff involved in critical response functions. **Training Needs Analysis.** **Training Records.**	Fully compliant	

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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 suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. Our Incident Coordination Centres (ICCs) are designed to be flexible and scalable, accommodating a range of incidents and operating hours as required. The trust has ICCs in place at both sites, with an alternative fall-back location identified. The ICCs were effectively utilised during the recent industrial action. Our ICCs are operational areas and are 'exercised' daily, with regular checks conducted by EPRR. Equipment within the ICCs is tested in line with national guidance or after major infrastructure changes to ensure functionality and readiness. Supporting documentation for the activation and operation of our ICCs is available and virtual arrangements are in place to supplement physical facilities, ensuring resilience with alternative contingency solutions. The ICC Protocol and Incident Management Team (IMT) Standard Operating Procedure (SOP) support these arrangements. The Strategic Incident Coordination Centre was utilised during the Strategic tabletop exercise in September 2024. Both the Tactical and Strategic Incident Coordination Centres were fully operationalised/stood-up during the Business Continuity Incident on 19.07.24. **Incident Coordination Centres Protocol.** **EPRR Policy.** **EPRR - Incident Management Team SOP.**	Fully compliant	
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Response documents are available on the intranet, SharePoint, and in hard copy within the ICC. The EPRR Manager ensures version control is maintained on these documents. Response staff are aware of where to locate plans. Additionally, processes are in place for retaining documents for required periods. **Screenshot of Website.** **SharePoint Screenshot.**	Fully compliant	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The Trust has a Business Continuity Incident Response Plan and in addition all critical services within the trust have individual business continuity plans to mitigate against various scenarios, such as loss of premises or electricity. Currently, there are 80 BCPs within trust services, each reviewed regularly or upon activation/key changes, and all detailing action cards and escalation processes. These BCPs are accessible electronically on the intranet, with hard copies available locally and in the Major Incident cupboard in the Tactical Incident Coordination Centre. Business continuity plans are reviewed within their divisions, with the process monitored by the EPRR Manager. Concerns are escalated to divisional leads and through the EPRR Committee meeting. A spreadsheet of the BCPs is maintained and manually monitored on a monthly basis by the EPRR Manager. **Screenshot of BCP's in SharePoint/Hard copies in TICC.** **Business Continuity Incident Response Plan.**	Fully compliant	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The trust has a bank of trained Loggists available 24/7, with their contact details located within the TICC and SICC. Key response staff are aware of the need to create their own personal records and decision logs in the absence of a trained loggist, ensuring that records are kept and stored correctly according to 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 utilising a loggist and underscores the importance of maintaining a log. Record retention details are also included in the Major Incident Plan. Action cards highlight the need for staff to start a personal log before a trained loggist takes over. Throughout the training and exercising sessions conducted this year, response staff and Loggists have participated to strengthen their understanding. This ensures a robust working relationship during incidents. Log books are readily available in the ICC for immediate use. **Log book.** **Loggists Details.** **Exercise Clear Voice Report.** **Major Incident Plan.** **Training records/TNA.**	Fully compliant	

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30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Processes are in place for receiving, completing, authorising, and submitting SitReps. A single point of contact (SPOC) email inbox is monitored daily by the EPRR Manager and Trust Operational Officers. The trust ensures effective communication through various meetings and calls: - Weekly Strategic Operations Group - Daily System Control Centre Call at 10:30 - Daily bed meetings at 09:00, 13:00, 16:00, and 19:00, administered by the Capacity Management Team The process for completing, quality-assuring, signing off, and submitting SitReps is well-documented and well-rehearsed. The SPOC circulates, follows up on, and submits SitReps, ensuring timely and accurate reporting. The trust has access to the standard SitRep Template, and the processes have been tested and exercised to ensure readiness during incidents. Processes have also been successfully activated during Industrial Action incidents over the last year. **SitRep Templates.** **Major Incident Plan.**	Fully compliant	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Key clinical staff have access to the Clinical Guidelines for Major Incident and Mass Casualty events either on the Intranet or a hard copy in the Emergency Department. **Screenshot of Intranet.** **Screenshot of SharePoint.** **Photo of hard copy/ICB to see in person.**	Fully compliant	
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Clinical staff have access to the CBRN incident: Clinical management and health protection Guidance either on the Intranet or a hard copy in the Emergency Department. **Screenshot of Intranet.** **Screenshot of SharePoint.** **Photo of hard copy/ICB to see in person.**	Fully compliant	
Domain 7 - Warning and informing							
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The trust has an overarching Communications Incident Response Plan. The communications team is fully aware of the organisation's incident response plan and the procedures for reporting potential incidents. Staff have been trained in incident terminology to ensure accurate declarations in line with the NHS EPRR Framework. Measures are in place to ensure incidents are appropriately described and declared. Contact details for on-call communications staff are available 24/7 within the ICCs or via Switchboard. A media-trained member of staff is available around the clock to support senior leaders during incidents. The communications team maintains a process for logging incoming requests, tracking responses, and ensuring that all information related to incidents is stored effectively. All email correspondence received via the EPRR route is stored within Outlook folders or the Trust SharePoint folders. Records of all inquiries received by the communications team are meticulously kept to provide evidence if required for an inquiry. **Communications Incident Response Plan.** **Adverse Weather Alert Emails.**	Fully compliant	
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 in place, which includes arrangements for communicating with partners and stakeholder organisations during and after an incident. The Communications Team is responsible for administering, reviewing, and exercising this plan regularly to ensure its effectiveness. The plan was activated during the Water Supply business continuity incident and the comms team have been heavily involved during the Industrial Action and other incidents which have taken place this past year. The plan was also utilised during the mass casualty exercises which took place in September 2024. A 'news reporter' also requested a media statement as part of the exercise. The plan is available as a hard copy in the ICC, alongside the Major Incident Response Plan and key contacts guidelines. The comms team keep a spreadsheet capturing all of teh inbound media request which are received into the Trust and collate responses. The team also keep a daily communications log to capture any mentions of the Trust or anything which may be relevant. **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. Recent industrial action episodes have demonstrated successful communication via various platforms including the website, social media, and direct patient contact to manage appointment adjustments. Overall, the Communications Incident Response Plan is managed by the Communications Team to maintain readiness for any potential incident. **Communications Incident Response Plan.**	Partially compliant	N.B. Further evidence required to amend compliance rating: Can we evidence that the Trust publicly states its readiness and preparedness activiteis in annual reports within the Trusts own regulatory requirements? If not this will not be fully compliant.

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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 to facilitate rapid and structured communication via traditional media and social media channels during incidents. Key components of this plan include: Media Strategy and Spokespeople: Ensuring timely distribution of information to the media. A pool of trained media spokespeople is available to represent the organisation effectively at all times. Social Media Policy and Monitoring: A robust social media policy is in place, overseen by the Communications team, to monitor and track relevant information related to incidents. This enables the Trust to engage proactively and respond effectively on social media platforms. Protocols for Social Media Use: Specific protocols have been established for using social media to warn and inform stakeholders and the public during incident responses. These protocols ensure consistent and appropriate messaging across all social media channels. Overall, the trust's Communications plan is managed by the Communications Team, incorporating protocols for social media use and providing clear guidance to enhance communication effectiveness during incidents. **Communications Incident Response Plan.** **Social Networking and Blogging Guideline.** **Establishing and using work-related social media accounts.**	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, with 100% attendance recorded. **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 LRF. Although attendance at these forums and working groups falls within the remit of the Deputy COO (DCOO), where they attend as needed, the Trust's representation at the LRF is delegated to L&SC ICB. Information from the Trust is conveyed to these meetings via the ICB, and details from the meetings are cascaded back through the ICB EPRR team to the Trust's AEO and EPRR Manager, for further dissemination if necessary. Arrangements are in place to ensure relevant information is fed back to the Trust from the ICB, through the LRF general purposes minutes. Additionally, in July 2024, the EPRR Manager was added to the LRF Mass Casualties Task and Finish Group Teams channel.	Fully compliant	N.B. ICB (A Whitehead) attends on behalf of the Trust. Confirmed By Alison on 13/09/24
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 are currently finalising the signing off of an agreed mutual aid process. **Major Incident Plan.** **Draft Mutual Aid Agreement for L&SC.**	Partially compliant	N.B. Mutual Aid Agreement to be finalised by ELHT and submitted to LHRP/AEO's for agreement.
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 Resilience Direct, Teams, Email, Internet, and Telephone to share appropriate information externally and manage information sharing via command and control internally during incident responses. The EPRR Policy and Major Incident Plan emphasize the importance of adhering to the General Data Protection Regulation (GDPR) 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	

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45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The Trust is committed to undertaking business continuity and maintaining a Business Continuity Management System (BCMS) that aligns with ISO standard 22301. The overarching Business Continuity Policy incorporates the full BCMS commitment. **Business Continuity Policy** **Risk Management Policy** **Development and Management of Procedural Documents**	Fully compliant	

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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.**	Partially compliant	N.B. The Business Impact Analysis Template has been incorporated into the new BC Policy. Although we do have the processes and templates in place we do not as yet have sufficient BIA templates completed to provide as evidence, hence the Partially Compliant rating.
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, detailing how each service will respond, recover, and manage during disruptions to people, information and data, premises, suppliers and contractors, and IT and infrastructure. These plans undergo an annual internal audit and are reviewed and updated by the plan owner following organisational changes, plan activation, or lessons identified during exercises. The BCPs are developed using ISO 22301 and the NHS Toolkit. A central log of BCPs is maintained by the EPRR Manager, detailing their review, audit, and exercising status. A number of local business continuity plans were activated during the Trustwide business continuity incident on 19.07.24. **BCP Template** **Audit Template.** **BCP Log.**	Fully compliant	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Since the last core standards assessment, the Trust has implemented a business continuity exercise programme. The EPRR team has been leading on tabletop exercises, using a variety of exercise scenarios to test the robustness of the BCPs with services. This exercise programme is now fully established, with regular business continuity exercises continuing to take place. Post-exercise reports are provided to the services, containing actions and recommendations, which are monitored by the EPRR team and reviewed at the EPRR Committee. The programme includes discussion-based scenario exercises, followed by a debrief. This ensures that the Trust's business continuity plans remain effective and responsive to any potential disruptions. The Trust responded to a multi-system outage business continuity incident on 19.07.24 where a number of local business continuity plans were activated. **BCP Exercise Reports.** **Exercise Action Tracker.** **BC Incident Debrief Report.**	Fully compliant	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The Information Technology department has submitted all evidence items for the Data Protection and Security Toolkit for the 2023-24 year. The toolkit was submitted at the end of June 2024, in line with the national deadline, and achieved 'standards met' assurance. This annual certification confirms our compliance with data protection and security requirements, ensuring the Trust's commitment to safeguarding information. Confirmation was provided by L Magee (Head of Information Governance). **Data Protection and Security Toolkit.**	Fully compliant	
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	The BCMS is monitored by the EPRR Manager and reviewed by the EPRR Committee. Key Performance Indicators (KPIs) used for monitoring are captured within the BCMS. Reports on these KPIs and the outcomes of exercises are included in the annual EPRR board report, ensuring that the board is kept informed of the BCMS status and any necessary corrective actions. **BC Policy (including BCMS).** **Board Report.** **Exercise Action Tracker.**	Fully compliant	

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51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The Trust has a process for internal audit as referenced in the BCMS within the BC Policy. An EPRR annual summary report, statement of compliance, and audit are provided to the Trust Board in the form of the NHSE EPRR Annual Self Assessment assurance documents and the EPRR annual board report. The Trust maintains a cycle of business for external audits, which EPRR aligns with, though EPRR has not had an external audit since the last core standards submission. This structured approach ensures that audits are conducted at planned intervals to confirm conformance with the business continuity programme, and outcomes are reported. **BC Policy (including BCMS).** **Board Report.** **Audit Template.**	Fully compliant	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	The Trust has a process to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement, as referenced in the EPRR Strategy Policy and Business Continuity Management Plan. A record of BCP review dates, activation, and exercising is held by the EPRR Manager. Post-exercise reports are provided to services with actions and recommendations, which are captured and monitored by EPRR and reported into the EPRR Committee. Plan owners are required to review their plans annually, at a minimum, to ensure continuous improvement. This structured process ensures that improvements are documented, monitored, and integrated into the BCMS for ongoing enhancement. **BC Policy (including BCMS).** **Post Exercise Reports.** **Exercise Action Tracker.**	Fully compliant	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The BCMS outlines the process for assessing business continuity plans of commissioned providers or suppliers, ensuring alignment and interoperability with our own continuity arrangements. This process is detailed in our Business Continuity Management System. We encourage a Provider/Supplier Assurance Framework to verify that their business continuity arrangements meet our standards. A supplier audit template is included in the BC Policy for colleagues to use. The BCMS emphasises the importance of gaining assurance from providers or suppliers on whom we depend and requests visibility into their business continuity arrangements. Colleagues involved in contract management are reminded of this critical requirement. NHS Supply Chain has robust processes in place to assure continuity from their suppliers, ensuring that all dependencies are adequately safeguarded, as detailed at www.supplychain.nhs.uk/product-information/resilience/ **BC Policy (including BCMS).**	Partially compliant	N.B.Partially compliant because while I can confirm the process is referenced in the Trust BC Policy as part of the BCMS, I do not have any supplier BCPs as evidence of assurance. The Standard NHS T&Cs of supply include the need for BCPs to be held by all suppliers and includes the wording below with regards to them aligning to local trust plans: "The Supplier shall use reasonable endeavours to ensure its Business Continuity Plan operates effectively alongside the Authority's business continuity plan where relevant to the provision of the Services". As most contracts are let off the back of national agreements, this core standard is difficult to evidence at a Trust level. **The ICB to query with NHSE.**
Domain 10 - CBRN							
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Details of accountability for the Trusts HazMat and CBRN response, including emergency planning, are clearly outlined in the HazMat and CBRN Response Plan. Training and exercise requirements are also detailed within the HazMat and CBRN Response Plan to ensure readiness and proficiency in response protocols. Specific roles for hospital decontamination and their respective action cards are clearly defined within the HazMat and CBRN Response Plan, ensuring clarity and efficiency in emergency response efforts. The Decontamination Equipment Capabilities guideline specifies roles responsible for equipment checks and maintenance. **HazMat & CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.**	Fully compliant	
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	The Trust has implemented a HazMat & CBRN Response plan that comprehensively outlines response arrangements, operational protocols, required competencies, and procedures for managing hazardous waste. This plan includes a dynamic risk assessment process tailored to the presenting casualty, ensuring staff welfare is prioritised throughout and after the incident. The hazardous substance management pathway within the policy addresses the safe handling and disposal of hazardous waste, aligning with regulatory guidelines. The Clinical Business Manager/Specialty Business Manager for the Emergency Department assumes responsibility for conducting risk assessments (RAs) across Trust sites where decontamination may occur. These RAs evaluate potential impacts on staff, estates, and infrastructure, including considerations for access and egress. They also assess the impact of decontamination procedures on critical facilities and services, ensuring continuity of operations during emergencies. This structured approach ensures that Hazmat/CBRN risk assessments are robust, responsive to varying scenarios, and integral to maintaining the safety and functionality of Trust facilities. **HazMat & CBRN Response Plan.** **ED Risk Assessment.**	Fully compliant	

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57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Contact details for the 24-hour on-call consultant from the UK Health Security Agency are included in the HazMat and CBRN Response plan and displayed in the Emergency Department and ICC. This ensures accessibility for key clinical staff needing specialist advice during HazMat/CBRN incidents. Additionally, the plan outlines procedures for accessing other specialist clinical advice as needed, with relevant contact information provided. The plan also references NHS England guidance to further support clinicians in managing patient care effectively during such incidents. The plan also specifies the decision-making process that follows upon receipt of specialist advice. These arrangements ensure that staff are well-informed and prepared to access timely and appropriate specialist advice for ongoing patient treatment. **HazMat and CBRN Response Plan.**	Fully compliant	
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •Command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	The Trust has a robust HazMat and CBRN Response plan in place, supported by the Decontamination Equipment Capabilities guideline, both accessible on the intranet or as hard copies within the ED. These plans provide comprehensive details on response arrangements tailored to the Trust. Effective processes for activating and deploying HazMat/CBRN staff and Clinical Decontamination facilities are established. Pre-determined decontamination locations are clearly defined, distinguishing between clean and dirty areas, ensuring safe patient access and cordon control. The plans outline protocols for both dry and wet decontamination, with clear decision-making criteria. Staff decontamination and welfare provisions are prioritised, alongside business continuity plans to maintain normal patient acceptance and decontamination capabilities via designated clean entry routes. Furthermore, the plans address hazardous waste management, transition from response to recovery phases, and procedures for obtaining replacement PPE/PRPS during incidents. This structured approach ensures readiness for HazMat/CBRN incidents and supports a swift return to business as usual operations. Staff training is delivered by Northern Care Alliance with in-house refresher training. Additionally, NWAS delivered Train the Trainer training in August 2024. **HazMat and CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.** **Training Records and TNA.**	Fully compliant	
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	The Trust maintains adequate and appropriate decontamination capability to handle self-presenting patients round the clock. Trained staff are readily available to operate these facilities, as outlined in the HazMat and CBRN Response plan, which specifies documented roles for the decontamination team, including the Entry Control/Safety Officer. CBRNe training and staff availability are overseen by the Clinical Educator for ED. All Band 7 ED staff have completed comprehensive CBRNe/HazMat and PRPS training, conducted over two days by the Northern Care Alliance, with plans for transition to NWAS training. A train-the-trainer course delivered by NWAS occurred over two days in August 2024. Identification of HazMat/CBRNe trained personnel is logged in the ED allocation book at the beginning of each shift. The Trust has assessed and identified suitable areas for mass decontamination at both hospital sites in collaboration with NHSE, NWAS, and LFRS colleagues. This collaborative effort ensures alignment of HazMat/CBRN plans and procedures with local area plans, enhancing readiness and response capabilities across the region. **HazMat and CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.** **Decontamination Equipment Audit.**	Fully compliant	
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/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://webarchive.nationalarchives.gov.uk/20161104231146/https://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 equipment to ensure safe patient decontamination and staff protection. An inventory of equipment is managed by the EPRR Manager, with regular checks to ensure readiness and functionality. Recent upgrades at Chorley & South Ribble Hospital in 2023 have enhanced their decontamination facilities, increasing capacity to accommodate more self-presenting patients. Additionally, Royal Preston Hospital now features a fixed decontamination unit capable of simultaneously decontaminating up to 6 self-presenters. To bolster readiness, Royal Preston Hospital retains an articulated decontamination tent as a backup should the fixed unit require maintenance. Both hospital sites adhere to NHS England guidelines by maintaining the minimum required number of PRPS suits, meticulously following manufacturer's maintenance protocols. The Trust is committed to ensure equipment, including PRPS suits and decontamination facilities, are appropriately maintained and replaced in accordance with their expected lifespan. **HazMat & CBRN Response Plan.** **Decontamination Equipment Capabilities Guideline.** **Decontamination Equipment Audit.**	Fully compliant	

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61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in 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 Manager conduct annual PPM checks, most recently completed in August 2024 by the EPRR Manager and ED Unit Manager/Senior Sister. Ram-Gene monitors undergo monthly checks by the ED Team as per manufacturer instructions, with annual servicing facilitated by nuclear medicine colleagues and records maintained in ED. PRPS suits are monitored in accordance with Respirex guidelines under the oversight of the EPRR Manager. Decontamination facilities undergo annual testing to maintain operational integrity. Other essential equipment is routinely inspected by the ED team and/or EPRR Manager, with comprehensive records of all checks kept by the EPRR Team. Details of the PPM process are outlined in the Decontamination Equipment Capabilities guideline, ensuring adherence to industry standards and manufacturer recommendations. This structured approach, including oversight by the EPRR Committee, guarantees that equipment remains operational and ready to respond effectively to Hazmat/CBRN incidents while supporting ongoing business continuity arrangements. **Decontamination Equipment Capabilities Guideline.** **Decontamination Equipment Check List.** **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.** **Waste Management Policy.**	Fully compliant	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Training for Hazmat/CBRN response at the Trust is comprehensive and aligned with our organisational Hazmat/CBRN plan and associated risk assessments. A Training Needs Analysis (TNA) ensures our training programme is tailored to the specific needs of our response staff, particularly focused on decontamination procedures. Currently, we have 80 staff trained in Hazmat/CBRN response, with ongoing efforts to expand this number through a rolling training programme. Training sessions cover essential areas such as PPE/PRPS use and decontamination practices, delivered both internally and through collaboration with Northern Care Alliance. To ensure continuity and high standards, we have 8 trained trainers within our Emergency Department who facilitate our internal Hazmat/CBRN training programme. These trainers have completed PRPS/CBRN Hazmat Train the Trainer Training either through Northern Care Alliance or with NWAS. Delivery of all HazMat and CBRN training will now move across to NWAS, with the initial train the trainer course having taken place in August 2024. All response staff are further supported by an e-Learning package developed by our ED Team and internally refresher training. Training records, including dates of attendance and certification, are held by the ED Clinical Educator, ensuring our staff remain proficient and up-to-date in Hazmat/CBRN response protocols; figures are also collated by the Trust training compliance team. This structured approach to training ensures our staff are well-prepared to manage Hazmat/CBRN incidents effectively, enhancing both operational readiness and patient safety. **EPRR TNA.** **HazMat & CBRN Response Plan.** **HazMat/CBRN Training Records.** **Blended Learning Figures.**	Fully compliant	
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	CBRN awareness training is mandatory for all Emergency Department staff, ensuring they understand the principles of Initial Operational Response (Remove Remove Remove) and the necessity for patient isolation when required. This training requirement is integral to our Emergency Department training programme, overseen by the Emergency Department Clinical Educator. Staff responsible for patient decontamination are specifically trained to implement a safe system of work, ensuring effective management in potential hazardous situations. A live CBRN Decontamination exercise took place in September 2024; Exercise Hose Down tested the reponse of ED colleagues from the Reception staff when the self-presenter entered the ED, through to the operational decontamiantion response team, triaging, treating and decontaminating the patient. Lessons identified from this exercise have been captured and an action plan put in place to address and implement lessons and strengthen future responses. **EPRR TNA.** **HazMat/CBRN Training Records.** **Blended Learning Figures.** **CBRN eLearning.**	Partially compliant	N.B. Reception staff training improvements required.

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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 suits, available around the clock. These suits undergo regular maintenance by Respirex, ensuring compliance with service and expiry dates, as well as necessary filter/battery changes. The EPRR Manager maintains detailed records related to PRPS maintenance. The HazMat and CBRN Response plan specifies the location of PPE and outlines appropriate usage based on risk assessments. Additionally, the Decontamination Equipment Capabilities guideline provides comprehensive instructions on PRPS use. **HazMat and CBRN Response Plan.** **Fit Mask Compliance Figures.** **Decontamination Equipment Capabilities Guideline.** **PRPS Maintenance Log.**	Fully compliant	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	The Trust ensures that HazMat/CBRNe plans and arrangements are integral to its EPRR exercising and testing programme. This includes a scheduled series of exercises aimed at testing and refining response capabilities. Recently, an unannounced exercise involving the deployment of the articulated tent was conducted at RPH. In addition, the new decontamination unit at RPH underwent an exercise in September 2024, while plans are in place to conduct a similar exercise at CDH in Spring 2025. These exercises are pivotal in evaluating the effectiveness of updated decontamination facilities at both RPH and CDH. Post-exercise reports captured key learnings and recommendations, facilitating continuous improvement of existing response plans and ensuring readiness to manage HazMat/CBRN incidents effectively. **Exercise Schedule.** **Post Exercise Reports.**	Fully compliant	

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Ref	Domain	Standard	Deep Dive question	Supporting evidence- including examples of evidence	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in EPRR arrangements. Amber (partially compliant) = Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)										
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	The IT team play a crucial role in supporting the Trusts EPRR activities. They are actively involved in the EPRR governance structure, with representation on the EPRR Committee, as detailed in the Terms of Reference (TOR) and meeting minutes. The team collaborates to ensure a shared understanding of potential risks to the Trust by contributing to Trust risk assessments and maintaining accurate risk registers. The IT team ensure that BCPs are robust and in place within their department, with additional local service BCPs outlining how they would address IT outages.	Fully compliant				
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'	Trust BCPs and disaster recovery plans for IT systems are in place and were activated during the multi-system outage on 19.07.24. The incident highlighted specific actions, which have been captured in the incident debrief and will be addressed by the IT Team.	Fully compliant				
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	The Trust's local business continuity plans include alternative communication methods to address potential IT/Telecoms outages, as highlighted during the recent multi-system outage. This incident emphasised the need for enhanced communication resilience due to increased reliance on digital systems and some further work required around this to ensure all colleagues are identifying/aware of suitable alternative methods of communication.	Partially compliant	This incident emphasised the need for enhanced communication resilience due to increased reliance on digital systems and some further work required around this to ensure all colleagues are identifying/aware of suitable alternative methods of communication.		
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	The trust's Communications Incident Response Plan includes a documented process for handling press releases during incidents. Local BCPs direct colleagues to refer all media inquiries to the communications team, which is available 24/7. Additionally, executive colleagues have received media training to ensure a coordinated and effective response. The Trust has plans which cover the management/use of both corporate and personal social media accounts. .	Fully compliant				
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	The IT team regularly resolves minor system outages and effectively managed the multi-system outage on 19.07.24 by forming an Incident Management Team. They quickly identified the issue, engaged executive colleagues, and communicated Trustwide updates both virtually and in person. Following the incident, a full debrief took place and report capturing lessons to be addressed by various teams. These lessons will be tracked through the EPRR Committee, ensuring continuous improvement.	Partially compliant	While our incident response was highly effective, the Trust has identified the need to enhance exercises in this area. Local business continuity exercises have already begun, focusing specifically on IT and system outage, scenarios.		
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	IT colleagues participated in the debrief following the incident on 19.07.24, where lessons were identified, and actions captured. Agreed processes are in place to ensure these lessons are adopted, with evidence of updated actions/plans tracked through the EPRR Committee, supporting continuous improvement.	Fully compliant				
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	The Chief Information Officer participates in Executive/Strategic training and exercises, with an IT representative expected to join the Strategic Incident Management Team.	Partially compliant	To enhance preparedness, we should consider that more IT colleagues participate in incident response training sessions, ensuring broader expertise across the team. This has already commenced, with IT colleagues attending Exercise Hibbert in September 2024.		
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package	The EPRR Awareness eLearning covers all types of incident response, including business continuity.	Fully compliant				
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisation's critical functions and the dependencies on IT core systems and infrastructure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	IT holds a list of core digital/IT systems and has Business Continuity/Disaster recovery plans to support these. Local service BCPs address IT outages and their impacts. However, there is no central list detailing the specific impact on each service if IT systems were lost.	Partially compliant	Explore feasibility for central list detailing specific impact on each service if IT systems were lost.		
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	The Business Continuity Policy includes IT failure as one of the key performance indicators which should be addressed when assessing impacts on critical functions. Risk assessments and Business Impact Analyses form part of the business continuity management cycle.	Fully compliant				
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Disaster recovery and business continuity plans are in place for core IT systems, ensuring the safe delivery of critical services.	Partially compliant	Need to verify that key personnel contact details are included and up-to-date within the IT recovery and business continuity plans.		

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Domain 1 - Governance									
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy outlines the necessary resources and roles needed to execute its functions including a description of EPRR staff. Whilst the EPRR function is currently being fully discharged, it is temporarily being supported by the capacity management administrative team. The Trust recognises that the EPRR team could be strengthened, and this will be re-assessed in the coming year. Additionally, the Trust has internal governance processes and organisational structure charts. **EPRR Policy.** **Structure Chart.**	Partially compliant	N.B. While the EPRR function is currently being discharged, the trust is at risk due to its dependence on a single individual in the role. This situation creates a single point of failure, as the entire service relies on one person. Despite the work being completed, the trust cannot be considered fully compliant. To ensure robust and resilient EPRR capabilities, additional support and resources are needed to mitigate this risk and ensure continuity in case of absence or turnover of the current individual in the role.		
Domain 2 - Duty to risk assess Domain 3 - Duty to maintain Plans Domain 4 - Command and control Domain 5 - Training and exercising Domain 6 - Response Domain 7 - Warning and informing									
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 • Arrangements for communicating with stakeholders 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) • How in place a means of communicating with patients who have appointments booked or are receiving treatment. • How 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. Recent industrial action episodes have demonstrated successful communication via various platforms including the website, social media, and direct patient contact to manage appointment adjustments. Overall, the Communications Incident Response Plan is managed by the Communications Team to maintain readiness for any potential incident. Communications Incident Response Plan.	Partially compliant	N.B. Further evidence required to amend compliance rating: Can we evidence that the Trust publicly states its readiness and preparedness activities in annual reports within the Trusts own regulatory requirements? If not this will not be fully compliant.		
Domain 8 - Cooperation									
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 ISP • 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 are currently finalising the signing off of an agreed mutual aid process. Major Incident Plan. Draft Mutual Aid Agreement for L&SC.	Partially compliant	N.B. Mutual Aid Agreement to be finalised by ELHT and submitted to LHRP&ID's for agreement.		
Domain 9 - Business Continuity									
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.	Partially compliant	N.B. The Business Impact Analysis Template has been incorporated into the new BC Policy. Although we do have the processes and templates in place we do not as yet have sufficient BIA templates completed to provide as evidence, hence the Partially Compliant rating.		
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The BCMS outlines the process for assessing business continuity plans of commissioned providers or suppliers, ensuring alignment and interoperability with our own continuity arrangements. This process is detailed in our Business Continuity Management System. We encourage a Provider/Supplier Assurance Framework to verify that their business continuity arrangements meet our standards. A supplier audit template is included in the BC Policy for colleagues to use. The BCMS emphasises the importance of gaining assurance from providers or suppliers on whom we depend and requests stability into their business continuity arrangements. Colleagues involved in contract management are reminded of this critical requirement. NHS Supply Chain has robust processes in place to ensure continuity from their suppliers, ensuring that all dependencies are adequately safeguarded, as detailed at www.supplychain.nhs.uk/product-information/resilience/ BC Policy (including BCMS).	Partially compliant	N.B.Partially compliant because while I can confirm the process is referenced in the Trust BC Policy as part of the BCMS, I do not have any supplier BCPs as evidence of assurance. The Standard NHS T&Cs of supply include the need for BCPs to be held by all suppliers and includes the wording below.with regards to them aligning to local trust plans: "The Supplier shall use reasonable endeavours to ensure its Business Continuity Plan operates effectively alongside the Authority's business continuity plan where relevant to the provision of the Services". As most contracts are let off the back of national agreements, this core standard is difficult to evidence at a Trust level. The ICB to query with NHSE.		
Domain 10 - CBRN									
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	CBRN awareness training is mandatory for all Emergency Department staff, ensuring they understand the principles of Initial Operational Response (Remove Remove Remove) and the necessity for patient isolation when required. This training requirement is integral to our Emergency Department training programme, overseen by the Emergency Department Clinical Educator. Staff responsible for patient decontamination are specifically trained to implement a safe system of work, ensuring effective management in potential hazardous situations. A live CBRN Decontamination exercise took place in September 2024. Exercise Hoxe Down tested the reponse of ED colleagues from the Reception staff when the self-presenter entered the ED, through to the operational decontamination response team, triaging, treating and decontaminating the patient. Lessons identified from this exercise have been captured and an action plan put in place to address and implement lessons and strengthen future responses. EPRR TNA. Hazmat/CBRN Training Records. Blended Learning Figures. CBRN eLearning	Partially compliant	N.B. Reception staff training improvements required.		
Deep Dive - Cyber Security and IT	0	0		0	0				
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your	The Trust's local business continuity plans include alternative communication methods to address potential IT	Partially compliant	This incident emphasised the need for enhanced communication resilience due to increased reliance on digital systems and some further work required around this to ensure all colleagues are identifying/aware of suitable alternative methods of communication.		
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	The IT team regularly resolves minor system outages and effectively managed the multi-system outage on 19	Partially compliant	While our incident response was highly effective, the Trust has identified the need to enhance exercises in this area. Local business continuity exercises have already begun, focusing specifically on IT and system outage, scenarios.		
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	The Chief Information Officer participates in Executive/Strategic training and exercises, with an IT represent	Partially compliant	To enhance preparedness, we should consider that more IT colleagues participate in incident response training sessions, ensuring broader expertise across the team. This has already commenced, with IT colleagues attending Exercise Hibbert in September 2024.		
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisation's critical functions and the dependencies on IT core systems and infrastructure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core ITD/digital systems and prioritisation of system recovery	IT holds a list of core digital/IT systems and has Business Continuity/Disaster recovery plans to support thes	Partially compliant	Explore feasibility for central list detailing specific impact on each service if IT systems were lost.		
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Disaster recovery and business continuity plans are in place for core IT systems, ensuring the safe delivery	Partially compliant	Need to verify that key personnel contact details are included and up-to-date within the		

Emergency Preparedness Resilience Response

Royal Preston Hospital,
Lancashire Teaching Hospitals NHS Foundation Trust

September 2024

Annual Report

Compliance |
Action plan for core standards 2023/24 |
Following last year's annual assurance submission and feedback from NHSE North West's check and challenge process, the Trust was advised to adjust its compliance rating from Substantial to Non-Compliant, with a score of 23%. In light of the significant work already undertaken to align with the new process, the Trust accepted NHSE North West's recommendations regarding the self-assessment.

The check and challenge process across all Trusts within the L&SC ICB footprint showed similar outcomes, with each Trust receiving a non-compliant rating. For comparison, Blackpool Teaching Hospitals NHS Foundation Trust achieved 31% compliance, University Hospitals Morecambe Bay 21%, East Lancashire Hospitals NHS Foundation Trust 16%, and Lancashire & South Cumbria Foundation Trust 10%. This benchmarking highlights the consistency of the process and results across the ICS.

Over the past year, we have attended monthly meetings with the ICB to demonstrate continuous improvement against the core standards and to update our action plan. Additionally, based on the check and challenge feedback, we conducted a comprehensive review of all core standards, reassessing them thoroughly to better align with NHSE and ICB requirements. This effort aims to improve our compliance rating for the 2024/25 assessment.

Core standards 2024/25 |
On the 13th of September, the ICB conducted a pre-assurance review at RPH, thoroughly examining each core standard with the EPRR Manager. For every standard, we were required to present supporting evidence to ensure our self-assessment met the necessary criteria. Over 150 pieces of evidence were reviewed and rigorously scrutinized. The primary goal was to verify that the compliance levels we proposed for submission were fully substantiated, providing assurance to the ICB and, subsequently, to NHSE for the 2024/25 submission.

Following this pre-assurance review, our annual self-assessment of core standards has undergone comprehensive evaluation. I am pleased to report that the ICB is satisfied with the progress made and the strength of the evidence provided. While a few minor areas require additional evidence to move certain standards from partial to full compliance, we will continue to address these gaps over the coming year to further improve our compliance rating.

As a result of this visit, our self-assessment for this year has been agreed upon as 'Substantially Compliant,' with an overall rating of 89%.

In addition to the pre-assurance review, the ICB will be conducting a dip sample of 5 to 6 core standards to gather further insights. This dip sample may focus on areas of concern identified during the review or areas of noted good practice. NHSE will also conduct a dip sample of providers, selecting one from each region. We are still awaiting confirmation on which core standards the ICB will select for the dip sample, whether LTHTr will be chosen by NHSE, or when these assessments will take place. Importantly, neither of these processes will affect our annual self-assessment submission, which was agreed upon by the ICB on the 13th of September.

Information Cascade |
Decontamination Facilities – Significant improvements have been made to the decontamination capabilities at both sites since the last report. Refurbishment work at CDH has been completed, resulting in a fully functional decontamination room equipped with two shower heads and clearly defined hot, warm, and cold zones. Additionally, a new fixed decontamination unit is scheduled to arrive at RPH in February 2024. Although the unit has

not yet been used for a live chemical incident, it has been successfully utilised on two separate occasions to assist self-presenters in removing non-caustic substances. This regular use of the unit not only ensures it remains operational but also enhances patient experience and increases staff awareness and confidence in handling the unit.

NHSE Site Visit 09.07.2024 – On 9 July 2024, Stephen Groves, Director of Resilience for NHS England, and Phil Storr, North West Regional Director of EPRR, visited Royal Preston Hospital to assess the incident coordination facilities, observe how EPRR is integrated within the Trust, and officially open the new decontamination facilities at RPH. The visit began with a brief presentation in the Strategic Incident Coordination Centre (SICC), where updates on EPRR improvements and integration within the Trust were shared. Security colleagues also provided insights into our state-of-the-art safeguarding system. Following this, they visited the Tactical Incident Coordination Centre (TICC) and the Security Control Room before meeting with Trust Chief Executive Silas Nicholls to formally open the new decontamination facilities. The visitors were highly impressed with all aspects of the visit and provided exceptionally positive feedback.

Martyn's Law - As of August 2024, Martyn's Law, formally known as the Protect Duty, is in the following stage: Legislative Progress: The bill has successfully passed through Parliament and is awaiting Royal Assent. This final step is expected to occur in late 2024 or early 2025. Once Royal Assent is granted, there will be a period of preparation and consultation to help organisations comply with the new requirements. The exact date for enforcement will be determined following Royal Assent, but organisations are advised to start preparing now. The law will require public venues with a capacity of over 800 people to: Conduct annual terrorism risk assessments, Develop, and submit detailed security plans and, Designate a senior officer responsible for overseeing compliance and preparedness.

Incidents |

Formalin Leakage 02.06.2024 – On two separate occasions, samples from theatres were sent to cellular pathology with lids that were not properly secured, leading to contamination of other samples and the destruction of accompanying forms. Staff were exposed to formalin, necessitating the evacuation of the area. The team promptly implemented business continuity plans by arranging an alternative location for samples, with several staff members coming in to support the effort. A swarm huddle (debrief) was conducted to review the incident, identify lessons, and establish an action plan. Fortunately, none of the staff involved reported any illness or injury related to the incident. During the huddle, it was noted that the Pathology team handled the situation exceptionally well, adhering strictly to all protocols. The incident has been documented on Datix (ID 162592) with key lessons identified during the swarm and subsequent actions are being closely monitored by Pathology Governance and Quality Team to ensure their full implementation.

Multi-System Outage 19.07.2024 – On 18 July 2024, CrowdStrike, an independent cybersecurity company, released a software update that began impacting IT systems globally. This outage was caused by a defect in a Falcon content update for Windows hosts. Microsoft, while not directly responsible for this incident, acknowledged the disruption and estimated that CrowdStrike's update affected 8.5 million Windows devices, accounting for less than one percent of all Windows machines.

The first reported system problems to the IT department were received at 05:53 AM on Friday 19 July 2024. IT colleagues promptly responded, working to identify the issue, assess its impact, and restore systems as quickly as possible. Additional IT colleagues supported directly in affected areas within the Trust. Business continuity was activated across the Trust, and paper-based systems were used where necessary.

The incident underscored the importance of teamwork and the dedication of everyone across the Trust in managing the crisis. The prompt response, effective communication, and collaboration between IT, clinical staff, and external agencies ensured that patient care continued despite the significant challenges faced. Moving forward it is crucial that all areas within the Trust work together to address the identified areas for improvement and implement the key recommendations and actions outlined in the debrief report.

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

NHS Blood & Transplant Amber Alert 25.07.2024 - A notification was received from NHS Blood and Transplant indicating an amber alert due to a shortage of group O cells. In response, the Emergency Blood Management Group was promptly convened, in accordance with the 'Emergency Blood Management Arrangements Procedure,' to review the relevant shortage plan and available guidance. The group developed strategies to manage the appropriate use of the affected blood and blood components. Once these strategies were established, they were overseen by the Hospital Transplant Team.

The frequency of meetings and the involvement of relevant colleagues were determined during the initial session and reassessed regularly as the situation evolved. The group initially met daily, before transitioning to weekly meetings as stock levels began to recover. The meetings will continue until the amber alert is lifted.

Southport Incidents 29.07.2024 and 30.07.2024 - on Monday 29th July the Trust received a major incident stand-by alert from NWAS relating to a stabbing incident in Southport, the incident was quickly stood-down for us, with no casualties received to the Trust. On Tuesday 30th July 2024, at 22:43, a major incident stand-by notification was received from NWAS. This was followed by a call at 23:03 declaring a Major Incident in Southport Town Centre involving a riot with police and vehicles on fire, resulting in nine injured officers (reported at that time). Emergency services, including police, fire, and ambulance, responded promptly. The incident led to the activation of the major incident call-out process at LTHTr. Although the trust remained on stand-by throughout the incident, a total of 14 P3 casualties were received, triaged, and treated in our Emergency Department (ED) at RPH. The situation was officially stood down by NWAS at 01:23, and all casualties were discharged by 06:00 on Wednesday 31 July 2024.

The response to the major incident for NWAS in Southport and the decision to declare a major incident stand-by for LTHTr demonstrated our ability to manage a sudden influx of casualties efficiently. Despite external communication challenges and initial uncertainties, the coordination between the Emergency Department, Capacity Management Team, Tactical Command, Strategic Command, EPRR, and other departments ensured that all casualties received timely care, demonstrating our robust emergency preparedness. This incident highlighted areas for improvement, particularly in communication and protocol adherence, and steps have already been taken to address these issues to enhance our future responses and ensure our teams are well-prepared for any future incidents.

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

General Practice Contractual Dispute August 2024 - In August 2024, a contractual dispute emerged between NHS England and general practice regarding funding and contract terms, focusing on financial allocations and service delivery expectations. This dispute could

potentially increase pressure on emergency departments (ED) and other services, as reduced capacity in general practice might lead to more patients seeking urgent care. Although this situation could strain resources and complicate patient flow and service delivery, no significant issues have been reported at this time. The situation is not currently managed through the EPRR route, but operational colleagues are actively monitoring the situation and participating in regular meetings on behalf of the Trust.

Mpox Virus 15.08.24 - The UK Health Security Agency (UKHSA) issued an urgent public health alert to all NHS service providers regarding the Clade 1 mpox virus (MPXV) infection, outlining key implications and recommendations for the NHS. In response to this alert, our Infection Prevention and Control team promptly established a working group and collaborated with colleagues in the Emergency Department to review and implement the guidance from UKHSA. This included updating the Trust policy for the 'management of patients with possible, probable or confirmed Mpox', reviewing the clinical pathway, and ensuring that appropriate PPE provisions were in place. As of the time of this report, no cases of mpox have been identified within LTHTr.

Loss of Water Supply at RPH 22.08.24 - On 22 August 2024, a significant disruption in the water supply affected the Preston and Blackburn areas, including Royal Preston Hospital. This disruption was caused by a technical fault at the United Utilities (UU) water treatment plant, resulting in a loss of mains water supply and reduced pressure. Immediate and coordinated action was required to maintain operations and ensure the continuity of critical services.

The water supply disruption was effectively managed through the coordinated efforts of the Estates team. While challenges were encountered, particularly regarding water supply stability and operational pressures, the incident was resolved with minimal disruption to patient care.

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

Suspicious Package at CDH 04.09.24 - The incident in question revolved around a patient who arrived at Chorley District Hospital feeling unwell and having left a suspicious package in her car, parked in public car park K. The clinical team swiftly assessed the patient in the emergency department (ED), determining no immediate health threat. Initial concerns about contamination from the patient led to the involvement of the Fire and Rescue service, as well as the police. The situation was complicated by a lack of early communication between the responding emergency services arriving on site and the hospital, leading to a delayed escalation and de-escalation process. It was quickly determined that there was no hazardous material involved, and the incident was stood-down.

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

Industrial Action – Consultants: 24-26/08/23, Joint: 19-23/09/23, 02-05/10/23, Junior Doctors: 20-23/12/23, 03-09/01/24, 24-28/02/24, 27/06-02/07/24. During all industrial action episodes throughout the year, an Emergency Planning Group met every Tuesday, with an oversight on a Friday morning in Strategic Operations Group (SOG) to discuss any upcoming industrial action, potential impact and planning required to mitigate service disruption.

Incident Management Teams were established to support during each of the industrial action periods with a Command-and-Control structure being in place 24/7 on all occasions, ensuring a robust response which complied with the EPRR standards.

No significant issues have been raised following any of the industrial action episodes to date.

EPRR Training & Exercising Programme |
Training |

EPRR Awareness

EPRR awareness is integrated into the Trust's Fire Safety eLearning package, ensuring that it is part of the mandatory training for all staff. Currently, 9,092 employees are fully compliant with this training. This broad awareness of EPRR is crucial to building a resilient workforce, capable of responding effectively to emergencies. It is essential that as many colleagues as possible within the Trust are familiar with EPRR protocols to ensure a coordinated and effective response during incidents, safeguarding both staff and patient safety.

Principles of Health Command (NHSE) Training – a 4-hour on-line training session delivered by NHSE North West which provides the knowledge and skills to our Tactical and Strategic Commanders to lead or support the response to emergencies. The Trust is currently 87.5% compliant for Strategic Commanders and 91.3% compliant for Tactical Commanders.

Health Commander Training – 2 training sessions have taken place since August 2023. The course objectives were aligned to the National Occupational Standards for our on-call commanders. The skills-based face to face course expanded on the learning from the PHC course provided by NHSE. The course objectives being some of the following: interpret information to develop awareness and assess challenges in dynamic situations, identify objectives and priorities to resolve dynamic situations, evaluate courses of action and develop options to respond to dynamic situations, use standard and informal techniques for communicating information, develop teamwork and leadership skills to collaborate in response to dynamic situations. The course covered situational awareness, communication methods, Decision Making and Planning, Briefing Stakeholders (from CEO to handing over to colleagues) and media training. The course really delivered a good variety of 'tools' to enable the commanders to have confidence and be competent in delivering not only a response role during an incident but methods which would be transferable in responding to day-to-day events that might arise when they are on-call.

A 3-year rolling training cycle is in place to ensure commanders remain confident and competent and to capture new colleagues with additional ad-hoc sessions to compliment this. The Trust is currently 94.4% compliant for Strategic Commanders and 91.3% compliant for Tactical Commanders.

Legal Awareness – There have been no additional legal awareness sessions this year. The Trust is currently 78% compliant for Strategic Commanders, number has dropped slightly since last year due to a few new colleagues on the Exec on Call rota (Strategic).

SCaN (See Check and Notify) - See, Check, and Notify (SCaN) training is an innovative training programme borne out of years of research and delivered by qualified Counter Terrorism personnel, SCaN aims to teach delegates how to: **See**: Recognise what's suspicious, and what isn't, **Check**: Understand the impact of friendly engagement to confirm or refute your suspicions and **Notify**: Know where and how to report if your suspicions are confirmed. SCaN aims to help organisations maximise safety and security using our existing resources. Our people are our biggest advantage in preventing and tackling a range of threats, including criminal activity and terrorism.

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

We have delivered 4 courses in the Trust to date with a 5th in the diary, attendance is extended to all Trust colleagues. The course invite was extended to other Trusts in L&SC, and we have had attendance from UHMB, LSCFT, ELHT and BVH colleagues.

ACT Awareness (Action Counters Terrorism) – In addition to the SCaN training an eLearning package has been developed to allow all colleagues to enhance their awareness.

CBRNe/HazMat – The training programme for our Emergency Department (ED) staff is now fully established, with staff attending a comprehensive 2-day training course provided by the Northern Care Alliance. This course covers all aspects of CBRNe/HazMat response, ensuring our team is well-prepared for these critical situations. Currently, 80 ED staff members are fully compliant with their CBRNe/HazMat response training, including RamGene radiation monitoring and the safe use of Personal Respiratory Protection Suits (PRPS). Additionally, we now have five more certified trainers who completed the Hospital Decontamination Train the Trainer course, delivered at RPH by the North West Ambulance Service NHS Trust in August 2024, taking the total to eight. This course was attended by Trust Operational Officers, ED colleagues and external EPRR colleagues from LSCFT, UHMB, BVH, and ELHT.

Our RPH ED trainers will continue to deliver in-house training to staff and provide annual refresher courses to ensure all colleagues remain confident and competent in responding to a CBRNe/HazMat incident. ED colleagues have also developed an eLearning package for CBRNe/HazMat, which is now available on Blended Learning for ongoing education and reinforcement.

Decontamination Equipment - Prior to the decontamination unit arriving at RPH 34 colleagues from portering, security, and the capacity management team were trained between August and September 2023 on how to deploy the articulated decontamination tent. To support continuous learning, the blended learning team have created a training video that allows colleagues to maintain their familiarity with tent deployment, ensuring preparedness in the unlikely event of a decontamination unit failure. Additionally, 84 ED colleagues have been thoroughly oriented to the new decontamination unit, enhancing our overall readiness.

Exercising |
Articulated Decontamination Tent 10.01.24 – An unannounced live exercise was conducted to evaluate the rapid deployment of the articulated decontamination tent at RPH. Upon receiving the call, five portering colleagues promptly responded, arriving at the decontamination tent location within minutes. Demonstrating their preparedness and efficiency, the team successfully deployed the tent within just five minutes of their arrival. This exercise not only showcased the team's swift response capabilities but also reinforced our readiness to manage potential CBRNe/HazMat incidents effectively.

6 Monthly Communications Exercise – Since the last report, four communication exercises have been conducted: Exercise Ken on 13/09/23, Exercise Hunt on 05/12/23, and Exercise Martha on 30/05/24. We are required to conduct a communications exercise at least every six months.

During Exercise Ken, a few areas, particularly within Theatres, failed to respond to the initial call due to poor mobile reception. Given that this was an unusual occurrence for the Trust, an additional exercise, Exercise Hunt, was conducted in December to ensure that this issue would not recur. No major issues were identified in that follow-up exercise.

Subsequently, a further communications drill, Exercise Clear Voice, was held on 24/04/24. This exercise was led by a colleague from the capacity management team, who was tasked with reviewing and verifying contact numbers within all incident response plans. Any anomalies identified during this review have since been corrected in the plans. Our next communications exercise is scheduled for November 2024.

Command Post - Since November 2022, we have maintained robust Incident Management Teams and Command & Control structures throughout various industrial action periods continuing throughout 2023 and 2024. This has involved activating various plans and processes, including managing reduced staffing levels, SitRep updates, escalation procedures, and utilising trained Loggists. Additionally, an incident management team was established in the Strategic Incident Coordination Centre during the multi-system outage on 19.07.2024 and a virtual Incident Management Team in place during the Water Supply business continuity incident in 22.08.2024. Although our response has largely been reactive, the command post structure was also tested during Exercise Hibbert in September 2024.

Mass Casualty - Exercise Hibbert, conducted on 18th September 2024, aimed to rehearse the Trust's Major Incident and Mass Casualty arrangements to reinforce and embed our Major Incident, Communications and ED Decant plans. The exercise was highly successful and involved LTHTr colleagues from ED, Theatres, Critical Care, Major Trauma, and Radiology, as well as multi-agency partners and stakeholders from various external trusts and emergency services. Lessons learned from this exercise will be monitored and addressed by the EPRR Manager and the EPRR Committee.

Lockdown - An unannounced out-of-hours lockdown exercise was conducted at Royal Preston Hospital's Emergency Department (RPH ED) on 01/12/23. The department successfully achieved a full lockdown within just 4 minutes. Feedback from all participants was highly positive, and no issues were reported during the drill, highlighting the effectiveness of the response.

Following this, a second lockdown exercise took place in the ED on 27/08/24, demonstrating similar efficiency and preparedness. Additionally, a lockdown exercise was carried out at the Sharoe Green Unit on 28/08/24. These drills are essential to ensuring staff readiness and refining lockdown procedures.

A full-site lockdown exercise is scheduled for the coming months, aimed at testing the preparedness of the entire facility and enhancing the Trust’s overall lockdown capabilities.

Business Continuity - During the multi-system outage on 19/07/24, several business continuity plans were activated, prompting a review and update of these plans by colleagues. Since January 2024, ten business continuity exercises have been conducted, with additional sessions scheduled. While these exercises are progressing well, there have been a number of last-minute cancellations by teams due to operational pressures. Lessons identified during these exercises are recorded by the EPRR Manager for reporting and monitoring via the EPRR Committee.

Plans Policies & Procedures |
EPRR Policy – In response to feedback from last year’s Core Standards check and challenge, the EPRR Strategy has been revised and divided into two distinct documents: the *Major Incident Plan* and the *EPRR Policy*. This separation follows best practice to ensure

clarity and accessibility. Both documents are available on Heritage, with the *Major Incident Plan* also accessible via the EPRR Intranet pages and the EPRR Incident Response channel on SharePoint. The *Major Incident Plan* was tested during Exercise Hibbert, which helped to refine and embed the plan within the Trust.

Adverse Weather Plan – During Winter 2023 and Summer 2024, the Trust received multiple Heat and Cold Health Alerts. In response, the EPRR team issued advisory emails to inform staff. However, the Adverse Weather Plan was not activated during these periods. The plan has undergone its annual review to ensure it aligns with current guidance and remains fit for purpose in handling future weather-related incidents.

Trust overarching Business Continuity Management plan – Following feedback from last year's Core Standards check and challenge, the *Business Continuity Management Plan* has been split into two updated documents, reflecting current guidance and best practice: the *Business Continuity Incident Response Plan* and the *Business Continuity Policy*. Both documents are available on Heritage, the EPRR Intranet pages, and the EPRR Incident Response channel on SharePoint.

Business Continuity Plans – Several BCPs within the Trust are currently overdue for review. This issue has been escalated through the EPRR Committee and divisional managers for oversight. Due to operational pressures, BCP reviews are not always prioritised among colleagues. To address this, the EPRR team is actively delivering BCP exercises to assess the robustness of our plans and has developed a BCP audit template to provide feedback on gaps or areas for improvement. However, the EPRR team's capacity is also limited, which poses a risk that some BCPs may not be as effective as they could be.
To reduce this risk, the new BCP policy has identified critical functions within the Trust. EPRR resources will be focused on these priority areas first to ensure they have robust BCPs in place.

All BCPs are accessible on the EPRR Intranet pages, and hard copies are stored in the Major Incident cupboard at Royal Preston Hospital.

Current/Potential Risks |
Energy Resilience – Nationally, energy resilience has received less attention during recent industrial action, with no new information or updates provided on this topic. As the anticipated power outages during the winter months did not materialise, it is possible that there will be no further developments until we approach Winter 2024. As highlighted in last year's report, we have secured protected site status for Royal Preston Hospital (RPH) and Chorley District Hospital (CDH), which ensures that the Trust's operations should remain unaffected by any planned power outages.

Resource & Funding |
EPRR Mandatory Training Costs – while EPRR training has been ongoing within the Trust, it has been funded through a successful £10,000 funding bid. Future budgeting for EPRR training will need to be addressed to ensure continued competency and compliance of our command staff with their EPRR training portfolios.

Strategic and Tactical Incident Coordination Centres (SICC/TICC) – the Gordon Hesling Conference Room serves as a dual-purpose space for major incidents, functioning as the SICC. Following its extensive refurbishment, it has proven effective, including during the multi-system outage. Conversely, the bed hub at RPH, intended as the TICC, was identified as inadequate for dual-purpose use following its activation towards the end of 2022. The EPRR Manager raised concerns with Kevin McGee (previous CEO) and was directed to consult with Jennifer Foote (Company Secretary). Approval was granted to explore a minor refurbishment of this space, but as of the time of reporting, no progress has been made.

EPRR Function – up until September 2024 the governance structure for EPRR included the Accountable Emergency Officer (COO, Katie Foster-Greenwood), Head of Patient Flow & EPRR (Annette Frodsham), and EPRR Manager (Sam Hughes), with Sam Hughes overseeing day-to-day EPRR implementation. As of mid-September 2024, following discussions with Executive team members, the EPRR function will now report directly to the Chief Operating Officer, underscoring its importance and Trust-wide corporate responsibilities.

The Trust's reliance on a single EPRR individual poses risks to operational continuity and statutory compliance. Due to the lack of funding for dedicated administrative support, the Clinical Business Manager for Patient Flow has integrated some EPRR administrative tasks into the corporate capacity facilitators' work schedule where capacity allows. Expanding the EPRR team remains crucial for improving resilience, coordination, resource optimisation, and training. To address these needs, an overview of the EPRR service, with potential expansion considerations, was presented to the CEO in August 2024 for review. A team-based approach will mitigate the risks of a single point of failure, ensuring better preparedness and safeguarding patient safety, staff, and operations during emergencies.

Report End
Sam Hughes | EPRR Manager

13.2 DATE, TIME AND VENUE OF NEXT MEETING: 6 FEBRUARY 2025, 1.00PM, LECTURE ROOM 1, EDUCATION CENTRE 1, ROYAL PRESTON HOSPITAL

Information Item | P White | 15:05