NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD ANCILLARY PAPERS

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3 June 2025

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AGENDA

BOARD OF DIRECTORS ANCILLARY PACK

Items:
9.2 - IPC Annual Report 2024-25
9.3 - Patient Experience Annual Report
9.4 - PSIRF Annual Report
10.2a - WRES
10.2b - WDES
12.2 - Risk Management Policy
13.2 - Maternity and Neonatal Safety Report

9.2 - IPC ANNUAL REPORT 2024-25

REFERENCES

Only PDFs are attached

09.2 - IPC Annual Report 2024-25 FINAL (002) Ancilliary papers.pdf

1. Introduction

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

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

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

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

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

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

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

- 4.3.1 – Using PSIRF principles review any themes and trends identified in Hospital Associated Gram Negative cases
- 4.3.2 - Standardise Continence and Bowel Care services across the ICB
- 4.3.6- Reduce Catheter Associated Urinary Tract Infections

- 6.2.1- To be compliant with the National Standards of Healthcare Cleanliness 2021
- 6.1.1 - Provide monthly reports to IPCC on Water safety

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

TRUST PERFORMANCE RELATED TO ORGANISMS OF CONCERN

1.1. MRSA Bacteraemia

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

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

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

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

1.2. *Clostridioides difficile* Infection

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

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

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

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

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

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

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

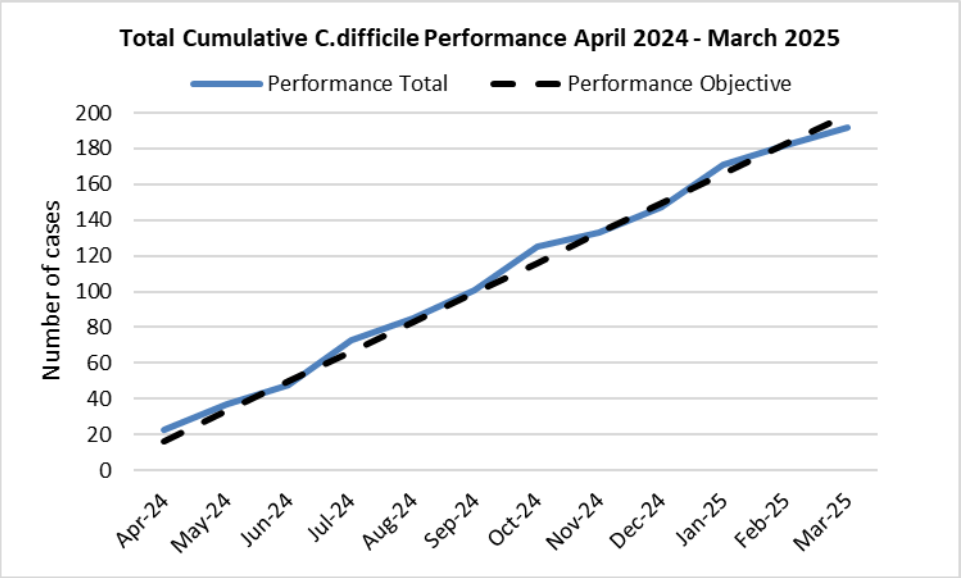
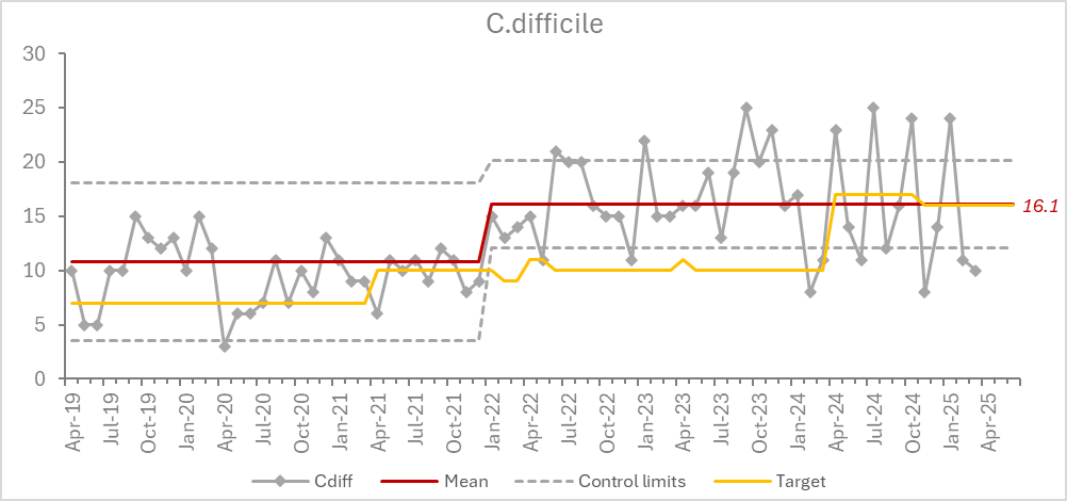


Figure 2 presents a Statistical Process Control (SPC) chart illustrating the monthly trend of Hospital Associated *C. difficile* cases per month from April 2019 to April 2025. A notable increase in cases is evident in 2022, which aligns with a Trust-wide policy change that expanded the definition of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

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



The National and Regional picture

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

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

C. difficile annual tables: cases & rates by Trust

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

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

Main developments during 2024/2025

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

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

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

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

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

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

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

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

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

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

Significant challenges and opportunities for 2025/26

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

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

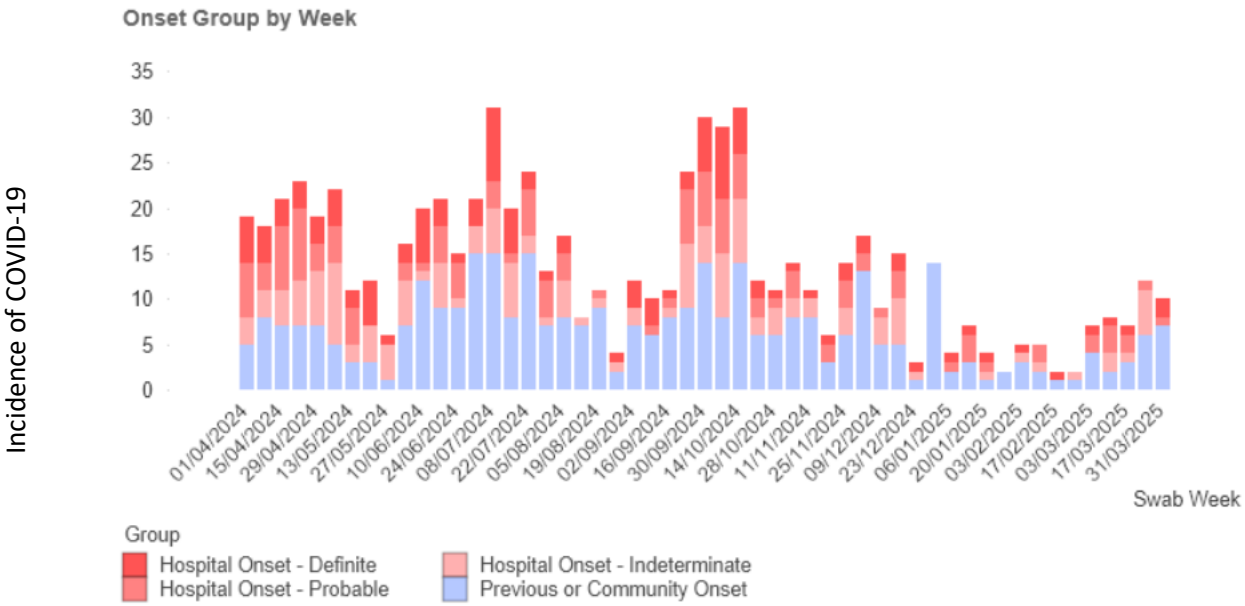
Implementation of the National Standards of Cleanliness, 2025
The adoption of the National Standards of Healthcare Cleanliness is expected to increase the frequency of surface cleaning on patient care areas. This enhanced cleaning regime is anticipated to reduce environmental contamination by spores,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

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

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

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

Figure 4 Hospital Onset versus Community Onset COVID-19 infections



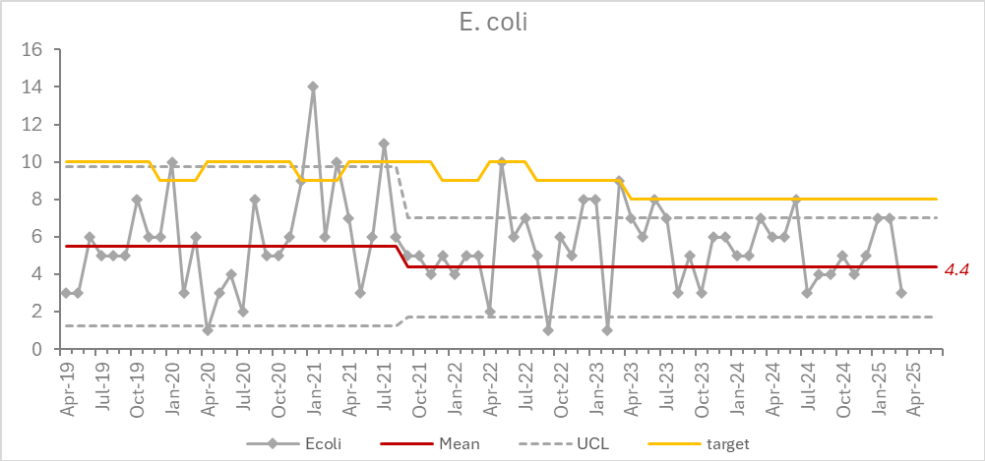
Source: LTHTR data

1.4. Gram-Negative Bacteraemia

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

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

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



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

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

1.5. OTHER OUTBREAK INVESTIGATIONS IN 2024/2025

1.5.1.1. Norovirus outbreaks

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

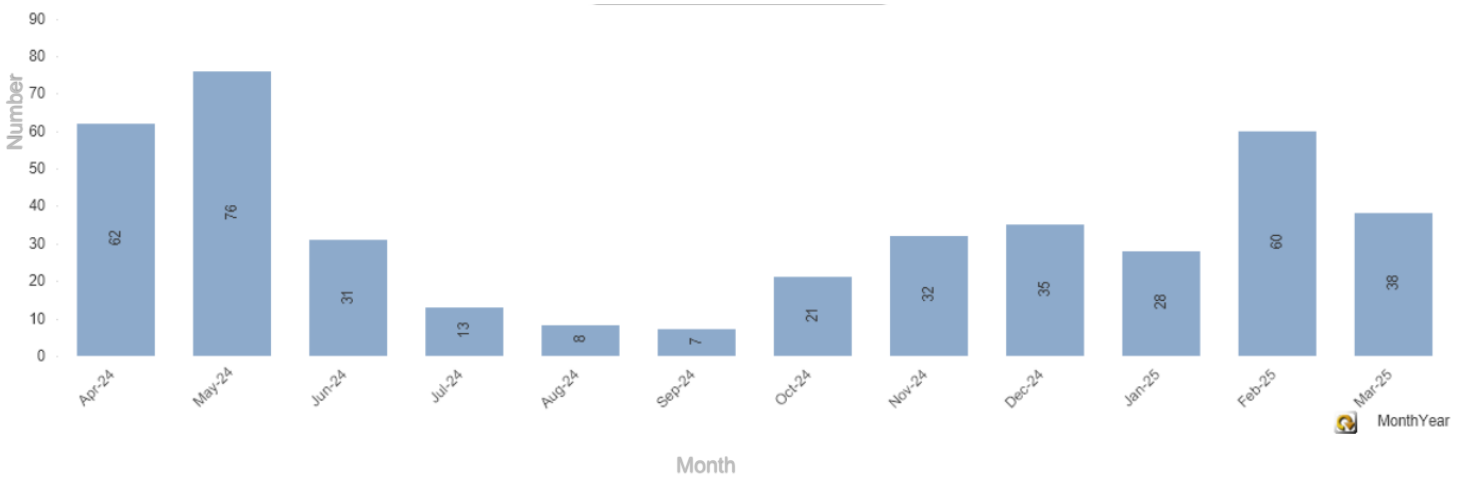
Between April and June 2024, and again from October 2024 through March 2025, there was an observed increase in the number of patients presenting to the Emergency Department and Assessment Units with symptoms of diarrhoea and vomiting, originating from community settings. This trend placed significant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

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

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

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

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



Source: LTHTR data

1.5.1.2. Influenza

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

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

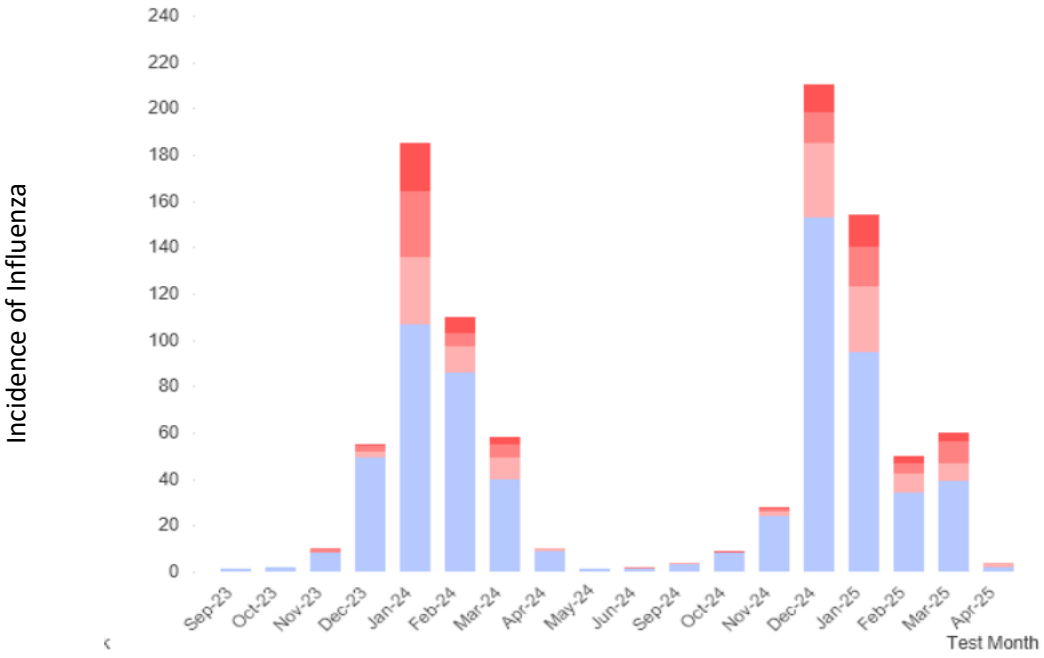
Isolation in single rooms and use of appropriate personal protective equipment (PPE) for suspected and confirmed Influenza cases is also key to preventing Influenza transmission in healthcare. When the number of single rooms exceed the single room capacity, cohort of Influenza cases can be implemented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

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

Influenza season 2024/2025

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

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



Source: LTHTR data

1.5.1.3. Measles National Outbreak

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

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

1.5.1.4. Carbapenemase-producing Enterobacterales (CPE)

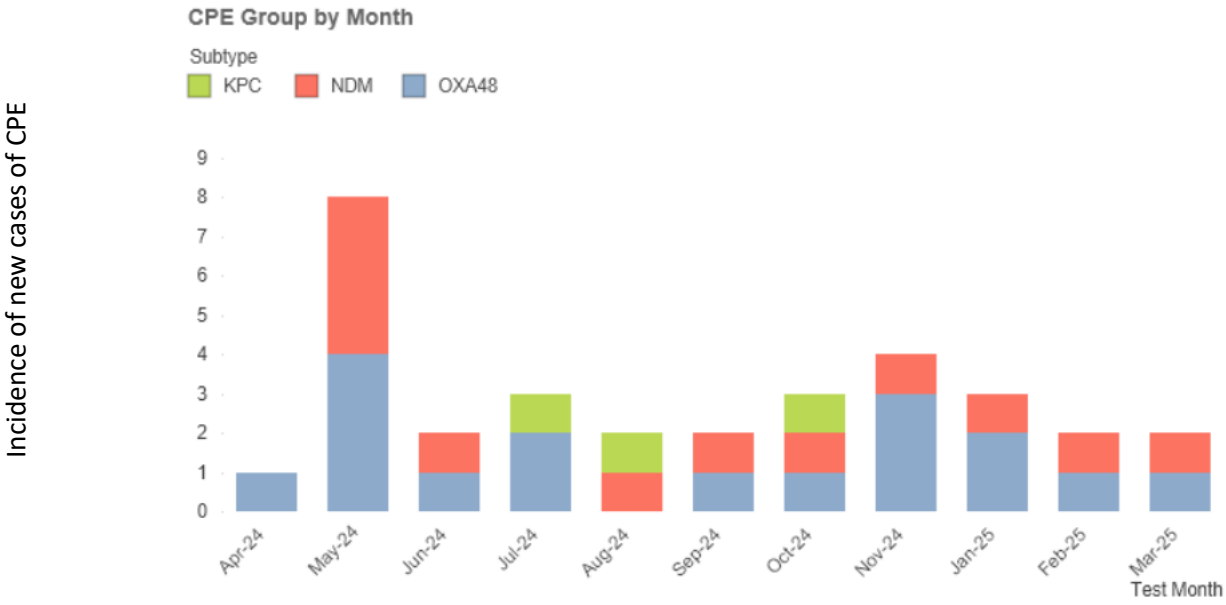
Enterobacterales producing acquired Carbapenemases are referred to as CPE. The most prevalent enzymes in the UK are KPC, OXA-48-like, NDM, VIM, and IMP. Increasing gut colonisation with these resistant bacteria will inevitably lead to an increase in difficult-to-treat infections. These strains of bacteria

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

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

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

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



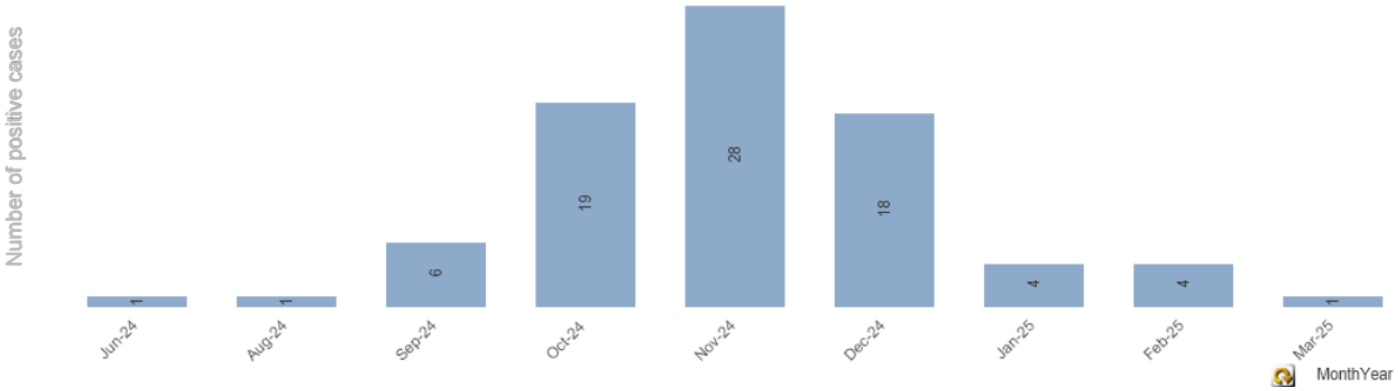
Source: LTHTR data

1.5.1.5. Respiratory Syncytial virus (RSV)

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

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

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



Source: LTHTR data

1.6. KEY INTERVENTIONS TO PREVENT NOSOCOMIAL INFECTION

1.6.1.1. Staff training compliance

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

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

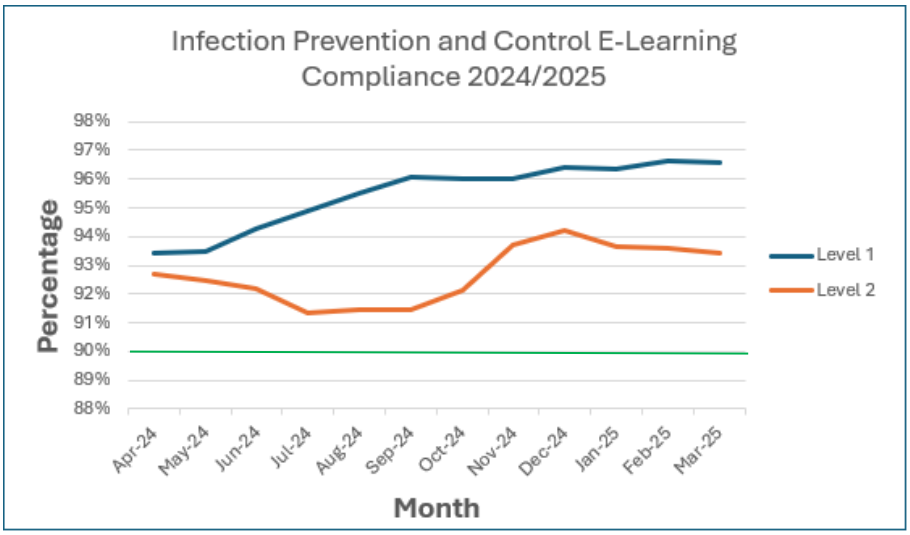


Figure 10 demonstrates that the Trust is achieving its target of over 90% compliance with IPC Mandatory training and this is consistent throughout the year. All Divisions are achieving this target (data not shown).

Matron and ward manager training

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

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

1.6.1.2. Assurance Platform

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

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

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

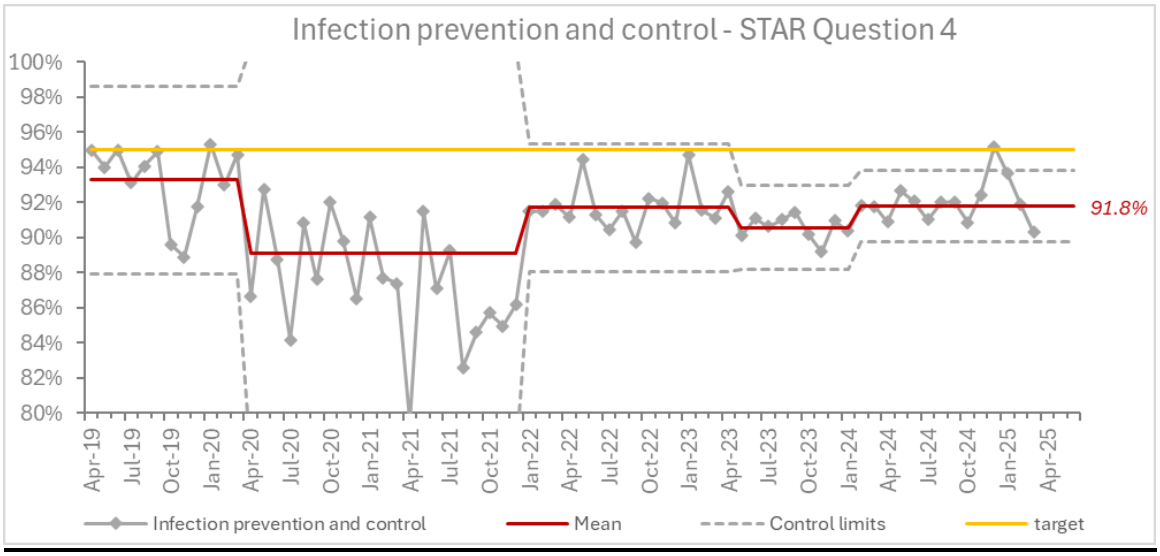
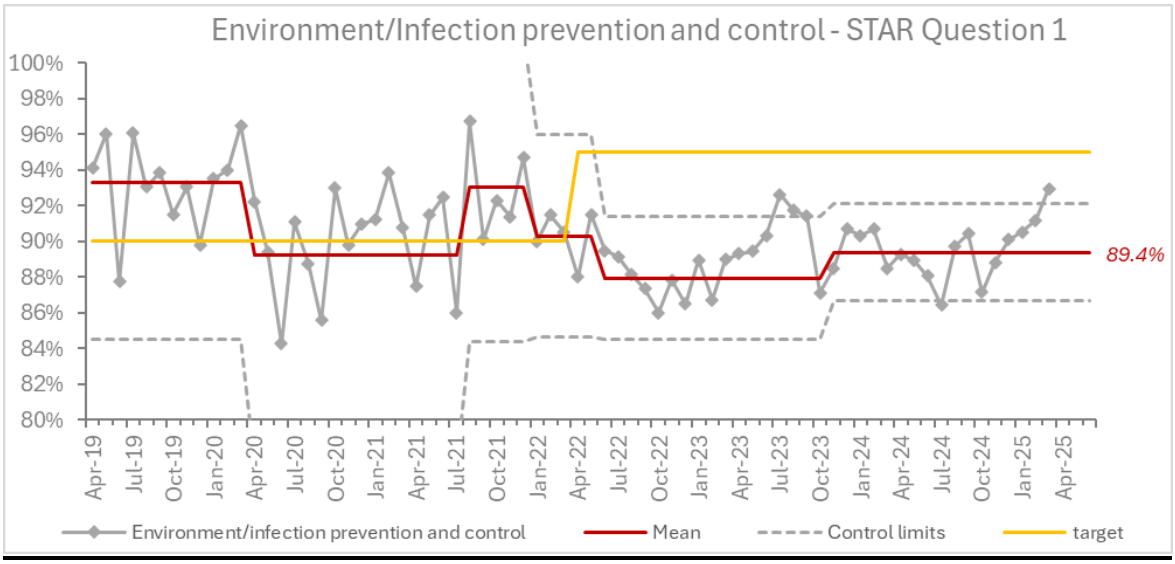


Figure 12 STAR accreditation compliance for Environment/Infection Prevention and Control (Department appears well-organised, clean and clutter free)



1.6.1.3. Antimicrobial Stewardship

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

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

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

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

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

1.6.1.4. Water Safety

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

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

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

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

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

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

1.6.1.5. Ventilation

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

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

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

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

1.6.1.6. Decontamination

The Sterile Services Department

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

Compliance with HTM01-01 Standards

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

Incident Reporting:

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

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

Staff Training

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

ISO 13485 Compliance

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

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

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

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

Decontamination in other areas of the Trust

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

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

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

1.6.1.7. Environmental Cleaning/Disinfection and Waste Management

Domestic Services

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

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

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

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

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

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

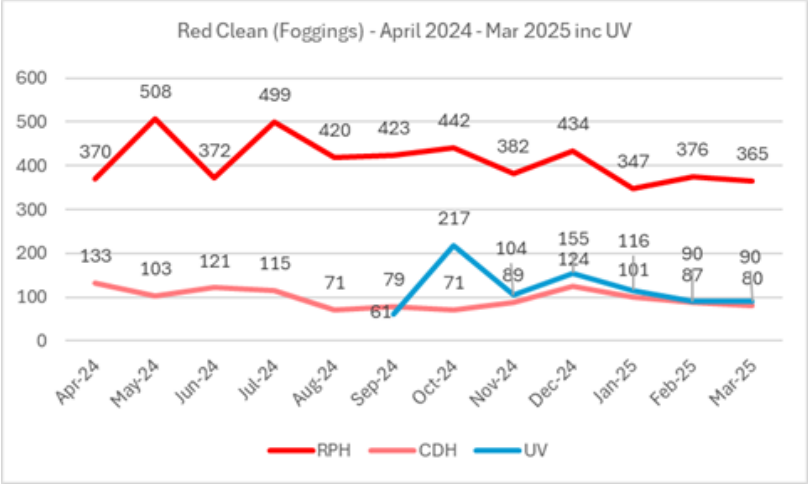
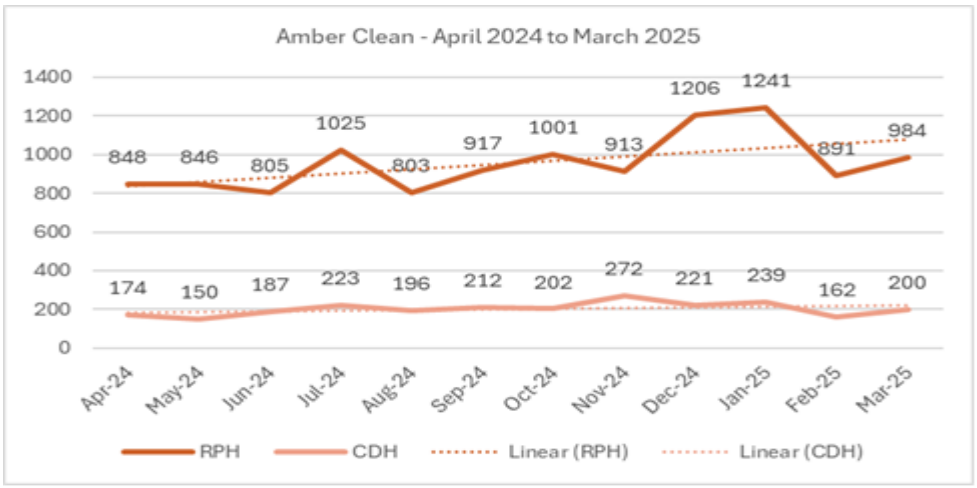


Figure 14 Amber Clean April 2024 - March 2025



Waste management

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

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

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

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

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

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

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

1.7 Research

Primel study

In October/November 2024, the IPC team successfully led the implementation of a research study investigating a novel hand hygiene product – Primel® Active Hand Coating (PAHC).

Unlike conventional alcohol-based hand sanitiser, PAHC not only provides immediate antimicrobial activity but also offers a sustained residual effect for up to 48 hours, even with routine hand contact, until it is washed

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

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

2. Financial implications

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

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

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

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

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

These will be managed through the Trusts governance processes.

3. Legal implications

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

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

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

4. Risks

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

5. Impact on stakeholders

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

6. Recommendations

It is recommended that subject to any review from the Safety and Quality Committee on 30th May 2025, the report be recommended for approval by the Board of Directors:

I. The Board of Directors note the contents of the Annual report and confirm that it is assured of progress against the 2024/2025 Annual Plan (Appendix 1).
II. Approve the IPC Annual Plan 2025/2026 (Appendix 2).

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

Appendix 5 - Community of Practice study day

9.3 - PATIENT EXPERIENCE ANNUAL REPORT

REFERENCES

Only PDFs are attached

09.3 - Patient Experience Annual Report 2025 Final reportv2 Ancilliary.pdf

1. Introduction

1.1. At Lancashire Teaching Hospitals, our commitment to delivering Excellent Care with Compassion remains central at the heart of everything The Trust aims to do. This annual Patient Experience and Involvement report reflects the voices of patients and their families over the past year, showcasing both the Trusts successes and the areas where continued improvement is necessary. By listening, learning and acting on patient feedback, the Trust is strengthening a culture where inclusion, respect and dignity are fully embedded alongside clinical excellence and safety.

1.2. This report outlines the significant progress made against the objectives of the Patient Experience and Involvement Strategy 2022–2025 (Appendix 1), a strategy developed collaboratively with patients, families, carers, governors, and staff. As the Trust concludes the final year of implementation, this report offers clear assurance to the Safety and Quality Committee of the progress made in delivering on our commitments and driving meaningful change.

1.3. Tangible advancements have been achieved across multiple areas of the strategy. In cases where targets have not yet been fully realised, these will be addressed through the Trust's Single Improvement Plan 2025/26 under the Safety and Quality domain. The report incorporates lived experiences from those who use our services and demonstrates how the strategy has been instrumental in deepening our understanding and enhancing service delivery to meet the holistic needs of our patients.

1.4. The annual report also provides assurance on the Trust's performance against key patient experience and involvement indicators, including complaints, response rates, Friends and Family Test results, patient surveys, and compliments. By ensuring that care is delivered both for and with patients supports the achievement of better outcomes and promotes care that is more efficient, productive, and cost-effective.

1.5. Oversight of the strategy and associated performance measures is maintained by the Patient, Carer Experience and Involvement Group (PCEIG). This group submits a monthly Chair's Escalation Report to the Safety and Quality Committee, ensuring robust governance and transparency.

1.6. A key metric of performance, the volume of complaints received, is detailed in Appendix 2 alongside the most common themes. We are encouraged to report a continued year-on-year reduction, with 325 complaints recorded during this reporting period, down from 355 in the previous year. This decline reflects our ongoing efforts to listen, respond, and improve

2. Discussion

1.1. The Patient Experience and Involvement Strategy

The Patient Experience and Involvement strategy has set the tone to listen more and act on patients' experiences. This means really listening to the experience of patients and families when they do and do not go well and using this to learn and improve. We asked patients, relatives, carers, colleagues, governors and patient and partner organisations to contribute to setting the actions in the strategy. We have actively sought the views of patient groups who represent those with protected characteristics and recognise the importance of intersectionality when considering this feedback. The Patient Experience and Involvement strategy has strong links with other Trust strategies including the Equality, Diversity and Inclusion strategy, the Mental Health, Learning Disability Dementia and the Autism strategies and patient experience and involvement will now be incorporated into the developing Single Improvement Plan.

The strategy was divided into 3 sections:

- Insight - improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.
- Involvement - equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.

- Improvement - design and support improvement programmes that deliver effective and sustainable change.

The year 3 outcome measures and progress against them are outlined in Appendix 1. It is important for Safety and Quality Committee to note that the strategy has remained a live and dynamic document. Whilst some outcome measures may be partially achieved, they continue to be monitored and have informed the development of future patient experience work. These efforts are now embedded within the Trust's Single Improvement Plan, ensuring continued alignment with broader quality and safety goals.

1.2. Positive highlights and assurances from 2024/2025:

Appendix 1 offers a comprehensive update on all the components targeted for action in the Year 3 strategy implementation plan, categorised under insight, involvement, and improvement. While the list isn't exhaustive, it highlights the key points and reflects the extensive efforts made to enhance experience over the three-year strategy period.

Insight

- Patient Experience Dashboard successfully developed and implemented, providing real-time insight into patient feedback and trends.
- Patient Experience embedded within the Trust's Continuous Improvement (CI) methodology and featured prominently in the training curricula of both the Microsystem Coaching Academy (MCA) and the Flow Coaching Academy (FCA).
- The developing focus on health inequalities saw a showcase as part of last year's Annual General Members' (AGM) Meeting, with the aim of raising awareness and driving engagement on this important topic.
- Complaints Review Group established, bringing together Governors, Patient Safety Partners, and staff to strengthen learning and transparency.
- Friends and Family Test (FFT) response rates improved by 4.7%, reflecting enhanced patient engagement.
- Expansion of Patient Forums, with increased participation from groups representing those who access our services, ensuring diverse voices are heard and acted upon.
- Full rollout of The Health Foundation's patients experience improvement scale, a research project led and coordinated by Imperial College which provides a structured framework for measuring and accelerating change over time.
- 71% of wards/areas accredited with STAR Gold, signifying excellence in care, environment, and patient experience.
- National Picker Cancer Patient Survey results demonstrate marked improvement, alongside sustained high performance in the National Maternity Survey.
- 76% increase in recorded compliments, indicating a significant uplift in positive patient feedback.
- Complaints reduced by 8%, with 325 received in the reporting period, compared to 355 in the previous year.
- New services and improved care pathways developed, with a particular focus on patients with additional needs and those from underrepresented communities.

Involvement

- Active involvement of the Trust's Patient Safety Partners and the Maternity and Neonatal Voices Partnership Chair in key committees, ensuring consistent representation of the patient voice at all levels of decision-making.

- 41% increase in early resolution training for PALS and Complaints teams, enhancing our ability to address concerns promptly and compassionately.
- 33% growth in our volunteer workforce, including the successful introduction of the 'Hospital Guide' role, supporting patients and visitors across the Trust.
- Strengthened engagement with the Deaf community, with dedicated representation on the Patient, Carer Experience and Involvement Group, promoting inclusivity and accessibility.
- Reintroduction of 'Our Health Day'—a tailored event supporting patients with learning disabilities, focused on health awareness, empowerment, and accessible care.
- 'CARING' walk rounds led by a diverse team, offering compassionate, person-centred support for patients and families at end of life.
- Patients sharing lived experiences at Community of Practice events and Board of Directors meetings, influencing improvement through powerful first-hand narratives.
- Enhanced interpretation services across acute areas, including Emergency and Maternity Assessment Units, with expanded 3-way calling capabilities and access to additional digital platforms—ensuring language is never a barrier to safe, timely care.
- Development and launch of the 'Patient Experience Portal', shaped by patient feedback, to improve accessibility and engagement with services and feedback tools.

Improvement

- Patients, Governors, and Patient Safety Partners participated in Patient-Led Assessments of the Care Environment (PLACE), with scores improving since 2023—reflecting enhanced care settings and environments.
- New Acute Medical Unit developed, supporting improved patient flow, timely assessment, and high-quality acute care.
- Baby Friendly Initiative (BFI) Stage 2 accreditation achieved, demonstrating a continued commitment to best practice in infant feeding and parent-infant relationships.
- Targeted improvement in postpartum care for women from Black, Asian, and Minority Ethnic (BAME) backgrounds, particularly in the management of postpartum haemorrhage, addressing health inequalities and improving outcomes.
- Youth workers introduced into Children's Services, providing dedicated support and advocacy for young patients during their hospital experience.
- Reduction in costs associated with lost property, reflecting improved personal belongings management and enhanced patient trust and satisfaction.
- Stoma-friendly bathrooms installed across the Trust, ensuring dignity, comfort, and accessibility for patients with stoma care needs.
- Children's Services at the CDH site received 'Getting It Right First Time' (GIRFT) accreditation, recognising excellence in clinical standards and patient care pathways.
- Trust-wide Learning Disability Plan launched, supported by mandatory Level 1 training for all staff to promote understanding, accessibility, and personalised care.
- Innovative whiteboard systems introduced in outpatient settings, enabling clear identification of patients requiring reasonable adjustments and enhancing tailored communication and support.

3. Patient, Carer Experience and Involvement Group

3.1 Over the past 12 months, the Patient Experience and Involvement group has continued to develop and expand. The group is well-represented by all divisions, patients, third sector partners, charities, governors, and advocacy groups. The meetings are now divided into two parts: Part A and Part B. Part A focuses on feedback and stories from patients, families, and carers, which are presented and

heard from each division to facilitate learning. The group's name has been changed to be inclusive of the experiences of families and carers and to ensure the carer voice is recognised

3.2 Part B focuses on understanding data and metrics. Quarterly reports from each division provide an overview of all aspects of patient experience across the hospitals.

3.3 Over the past 12 months, a review of the terms of reference and cycle of business has been conducted to clarify expectations for the group, ensuring alignment with the strategy and action plan. The group's aim is to achieve full representation from individuals with protected characteristics. This representation is continually improving, and it is anticipated that within the next 12 months, all protected characteristic groups will be represented.

4. Patient, Carer and Family Feedback

4.1 Complaints and Concerns (Appendix 2)

During the 2024/2025 reporting period, the Trust received 325 formal complaints, representing a reduction of 30 complaints compared to 2023/2024. This equates to a reduction of 8.45%. Complaint performance has been monitored throughout the year, with a notable improvement in timeliness of responses. The proportion of patients receiving a response within the designated 35- or 60-day timeframe has risen from last year with an average compliance rate of 82% across the year.

Whilst there has been a reduction in the complaints received by the organisation, some are more complex than previously. The trend in the ratio of complaints to patient contacts over the past three years is detailed in appendix 2 (Table 2.1).

Of the 325 complaints received between April 2024 to March 2025, 257 (79%) related to care or services provided at the Royal Preston Hospital (RPH), 60 (18%) to care or services provided at Chorley and South Ribble Hospital (CDH), 1 (1%) to care or services provided by Preston Business Centre, and 7 (2%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were deemed to be outside of the 12 months' timescale set out under the NHS Complaints Procedure.

During this financial year there were 307 cases closed. The outcome of this can be broken down into the following outcomes 17 (6%) of the complaints had been upheld. 178 (58%) were partly upheld and 102 (33%) were not upheld. 10 (3%) cases currently remain open at the end of the year.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 98% of complainants received an acknowledgement within that timescale where complaints were received by the Patient Experience and PALS team. Whilst 100% of patients receive an acknowledgement via email or verbally on the telephone. The 98% figure is taken from when the case is opened on the Datix Governance system to the time that the case manager contacts the complainant.

Second letters of complaint may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2024 and March 2025 the Trust received 16 second letters. The team remain focused on resolving complaints first time and learning from receipt of second letters will be embedded into improvements.

During the period 1st April 2024 to 31st March 2025 307 complaints were closed. 82% of complaints received in 2024/25 were closed within the 35-day or 60-day timescale. This is reported to the Safety & Quality Committee monthly. Of note the organisation is not mandated to respond within 35 days, however the standard set is to ensure that complainants receive timely responses to provide better

patient experience. The Patient Experience and PALS Team have dealt with a total of 2,058 concerns and 3,302 enquiries. There are 293 cases pending whilst awaiting further information from those who have raised concerns, such as consent and patient details.

4.2 **Complaints and Concerns (Appendix 2)**

While there are many more compliments than complaints, complaints are an important source of feedback. Key complaint themes across all divisions include communication, consent, confidentiality, treatment and procedure, and nursing care. To capture learning from complaints, the complaints review group is now in place and monthly update of complaint themes and presented initially through the Patient Experience and Involvement group and noted in individual divisional reports to this group. It is crucial to understand divisional challenges and the actions taken to address concerns and complaints.

Diagnostic and Clinical Support: The key themes for this division are communication, treatment/procedure, and nursing care.

Women and Children: The main themes here include communication, treatment/procedure, and staff behavior or attitude.

Medicine: For this division, the themes are communication, treatment/procedure, and nursing care.

Surgery: The primary themes are treatment/procedure, communication, and nursing care.

All divisions regularly present paper report updates to the Patient Carer Experience and Involvement Group (PCEIG) regarding the themes within their divisions and the associated actions for improvements. Many of these align with the findings from the national survey, which have individual action plans in place and are also monitored through PCEIG.

4.3 **The Parliamentary Health Service Ombudsman (PHSO)**

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2024 to 31st March 2025 there were 4 cases referred to the PHSO; 3 are ongoing, and 1 was partly upheld.

During this period, the PHSO sent final reports for 6 cases which were opened prior to April 2024 and the outcome of these were that 3 were not upheld, 2 were partly upheld, and 1 was upheld.

There is one further case referred to the PHSO prior to April 2024, which is still under investigation by the PHSO, and a final decision is yet to be reached.

4.4 **Compliments**

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2024/25 a total of 6,831 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been a 76% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and

divisions. The results from divisional compliments are now published monthly in the Trust Communications and discussed as part of divisional meetings.

4.5 **Friends and Family Feedback (Appendix 3)**

The Friends and Family Test (FFT) is a national measure used to assess patient experience by determining whether patients would or would not recommend the services provided by the hospitals to their friends and family. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

A target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity has achieved this in Q1 and Q4, Day case and Outpatients have consistently achieved more than 90% in all four quarters, Maternity, Inpatients and the Emergency Department are under the target percentage in all four quarters.

Although not a national requirement, the Trust undertakes surveys in Children and Young People's Services to ensure an equitable approach to measurement of experience. Children and Young People using the Urgent and Emergency pathways are reporting less favourable experiences. The day case and outpatient departments are demonstrating positive performance. The neonatal service has maintained a sustained performance of 100%. The data demonstrates an overall increase in responses and an increase in usage of the various methods of collection.

4.6 **Friends and Family response rate**

Expanding the methods used to collect feedback is important if we are to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 2,937 more valuable pieces of feedback than what was collected in 2023/24. It is not yet possible to view this feedback through the lens of protected characteristics and deprivation however, work is underway with Civica to ensure that gender and ethnicity is added to the Friends and Family questions in all formats and this will be extended to capture other groups of patients in future such as those who have a learning disability.

In the year 2024-2025 there has been a positive increase in the response rates overall of 4.7% in comparison to the previous year. Increases have been realised with paper surveys and short message service (SMS) text surveys. There has been a reduction in the telephone surveys and online surveys which in part may be due to an increase in SMS text surveys and paper preferences for service users. Staff are actively encouraging patients to complete the FFT before leaving the hospital, which in turn supports the increase in paper survey completion.

The Trust continues to provide ongoing training to staff on the use of the CIVICA system and ensure the patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded using the CIVICA system. Managers and leaders are actively seeking to make improvements with the Friends and Family test feedback. To support accountability and transparency, monthly FFT reports are distributed to governance and divisional leads, ensuring that results are reviewed, acted upon, and shared across the organisation.

4.7 **Care Opinion Website**

During the past financial year there have been a total of 198 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 124 compliments and 66 concerns and 8 that have provided both concerns and compliments.

4.8 **National In-Patient Surveys**

Maternity Survey 2024

The Maternity survey was based on a sample of inpatients during April and July 2024. A total of 324 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 318 patients were eligible for the survey, of which 103 returned their questionnaire, giving a response rate of 32%. This is a 7% decrease in response rate compared to the 2023 survey. The average response rate for the 56 'Picker' trusts in 2024 was 39%.

A total of 89 questions were used in the 2024 survey, of these 59 questions were asked in the 2024 survey. Compared to the 2023 survey, Lancashire Teaching Hospitals has remained in the same position as the 2023 survey. Overall mothers reported that they rated their experience (96%), they were treated with respect and dignity (during labour and birth) (93%) had confidence and trust in staff (during labour and birth) and (94%) were involved in decisions about their care (during labour and birth).

Urgent and Emergency Care Survey 2024

The survey was based on a sample of inpatients receiving care and treatment between April and July 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1195 patients were eligible for the survey, of which 363 returned their questionnaire, giving a response rate of 30%. This is a 5% increase on responses compared to the 2022 survey. The average response rate for the 64 'Picker' trusts in 2024 was 30%.

A total of 55 questions were used in the 2024 survey, of these 19 questions were comparable and asked in the 2022 survey. Compared to the 2022 survey, Lancashire Teaching Hospitals has not significantly improved in any areas, with 5 areas identified as significantly worse in 2024. Overall urgent and emergency care patients reported that they rated their A&E experience (65%), they were treated with respect and dignity (92%) and had confidence and trust in the doctors and nurses (92%). An action plan is in place to address the areas of deterioration reported in the survey.

Inpatient Survey 2023

The survey was based on a sample of inpatients between July and November 2023. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1176 patients were eligible for the survey, of which 470 returned a completed questionnaire, giving a response rate of 40%. This is a 2% increase on the 2022 survey. The average response rate for the 64 'Picker' trusts in 2023 was 43%.

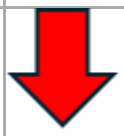
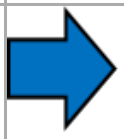
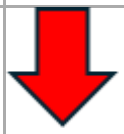
A total of 63 questions were used in the 2023 survey, of these 39 questions were asked in the 2022 survey. Compared to the 2022 survey, Lancashire Teaching Hospitals has significantly improved in 2 areas, with 1 area identified as significantly worse in 2023. Overall adult inpatients reported that they rated their experience 7/10 or more (76%), they were treated with respect and dignity (97%) and had confidence and trust in the doctors (97%).

National Cancer Patient Experience Survey (NCPES)

The 2023 NCPES is the thirteenth iteration of the survey. It has been designed to monitor progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. The 2023 survey involved 132 NHS Trusts with a response rate of 52%. LTHTR sample size was 1463 with a response rate of 55%.

The expected range charts in the national report show the lowest and highest score received for each question nationally. Trusts whose scores were above the upper limit of the expected range are positive outliers, with a score statistically significantly higher than the national mean. This indicates that the Trust performs better than trusts of the same size and demographics are expected to perform. The opposite is true if the score is below the lower limit of the expected range, these are negative outliers. Scores within the expected range are what would be expected given the Trust's size and demographics.

There were 61 questions in total and LTH scored 8 questions were in the higher-than-expected range with no responses in the lower-than-expected range. LTH has been consistently achieving a score of 8.9 (out of 10) and this was maintained even throughout the pandemic. We have now scored 9 consistently since 2021 and consistently above national average.

National Survey	Date published	Trust position nationally	Comparison to previous survey
Inpatient Survey	August 2024	52 out of 60	
Maternity Survey	December 2024	18 out of 61	
Cancer Survey	July 2024	No rankings but scoring improved	
Urgent and Emergency Care Survey	November 2024	46 out of 55	

5. Financial Implications

5.1 Although no direct costs have been attributed to this annual report, it is acknowledged that patient experience is closely linked to improved outcomes and efficiency. Therefore, ensuring a positive patient experience directly contributes to the efficient and productive operation of the organisation.

6. **Legal implications**

None

7. **Risks**

7.1 This paper provides details on Patient Experience data by positive and negative escalation and is aligned to risks identified on the risk register.

8. **Impact on stakeholders**

8.1 Patient experience is the most critical area within the organisation needing improvement, primarily due to issues with flow and communication. Both areas have dedicated strategies and improvement plans designed to address these challenges and associated risk assessments.

9. **Closing year 3 and moving to Single Improvement Plan**

9.1 As the trust transitions to a new single improvement plan, the current patient experience and involvement strategy will conclude. However, the patient experience agenda will remain a key focus, with specific objectives and milestones incorporated into the new plan. There will be a greater emphasis on feedback from patients with protected characteristics and those who are vulnerable, in alignment with the Trust's 'Our Health Plan'.

9.2 Appendix 1 of the review of the current strategy acknowledges that some aspects have not been fully achieved. These elements will either be incorporated into the single improvement plan or will continue to be addressed under the leadership of the Associate Director of Experience and Quality.

9.3 Those partially achieved objectives from the Patient Experience and Involvement have been identified as priorities for ongoing development within the single improvement plan and include:

Enhancing the collection and analysis of data related to equality, diversity, and inclusion to better inform service delivery and accessibility.
Increasing training uptake in relation to the PALS and complaints handling processes to ensure consistent, empathetic, and effective resolution of concerns.
Strengthening feedback mechanisms to ensure the voices of seldom-heard groups and individuals with protected characteristics are more effectively captured and acted upon.
Advancing the development of personalised care pathways to better meet the individual needs and preferences of our service users.

The Trust remains committed to continuous improvement in these areas and will continue to monitor progress closely, ensuring alignment with our overarching strategic objectives.

9.4 Following conclusion of the strategy, the proposed priorities for the Single Improvement Plan for patient experience and involvement 2025/2026 are:

A 25% increase in volunteers deployed across all wards and departments, with an emphasis on recruiting individuals who reflect the diversity of our local communities, ensuring robust collection of both quantitative and qualitative patient feedback.

Strengthened partnerships with local voluntary and community sector organisations to support the co-delivery of services and better reach underrepresented groups.

The implementation of quarterly qualitative patient experience reviews, focusing on individuals with learning disabilities, mental health needs, and dysregulated behaviour, with findings formally presented to the Patient and Carer Experience Improvement Group (PCEIG).

A targeted effort to increase the Friends and Family Test response rate by 5%, particularly among patients with protected characteristics.

Ongoing delivery of educational initiatives, with a target of 90% completion for PALS eLearning among all staff and 90% completion of complaints and local resolution training among Band 6 and above clinical staff.

Enhanced discharge support to improve patient, family, and carer understanding of discharge destinations, medication guidance, and post-discharge contacts.

Introduction of comfort packs, "About Me" boards, and timely patient information within Emergency Departments to improve the experience of those awaiting admission.

A 90% compliance target for all inpatients to view the patient safety video during their hospital stay.
Efforts to diversify the Patient Safety Partner role.

Continued emphasis on improving inpatient experience through consistent use of intentional rounding, enhanced care practices, and personalised “About Me” boards.

A focus on improving overall Trust performance in the UEC and In-Patient National Surveys.
Divisional focus on addressing the Trust’s top three themes, informed by trend analysis and aligned corrective actions.

10. **Equality, Diversity and Inclusion**

10.1 The Equality, Diversity, and Inclusion strategy is the golden thread woven throughout the Patient Experience and Involvement Strategy. It is crucial that we remain consciously inclusive in all our actions. To achieve true inclusivity and diversity, we must gather extensive information from the voices of patients who we do not hear from, with a particular focus on those with protected characteristics. Utilising Friends and Family feedback, Datix, and PSIRF, and aligning with Our Health Plan, will enable us to truly understand the diverse voices of our patients.

11. **Recommendations**

11.1 It is recommended that subject to any review from the Safety and Quality Committee on 30th May 2025, the report be recommended for approval by the Board of Directors:

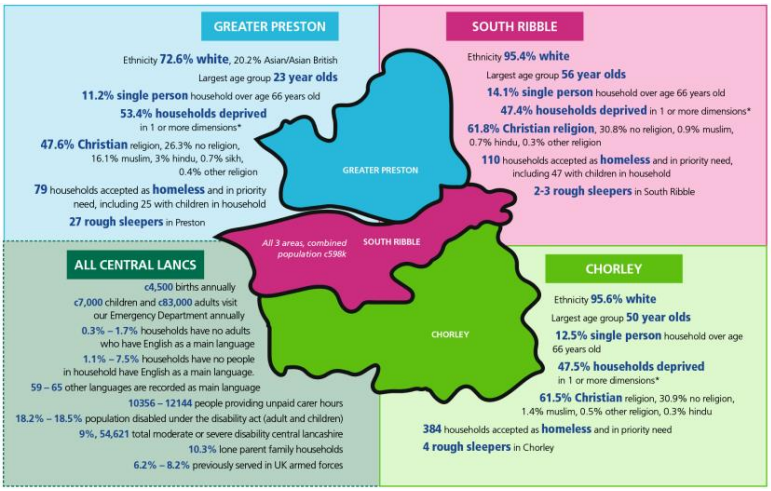
I. The Board of Directors note the contents of this paper and the attached action plan.

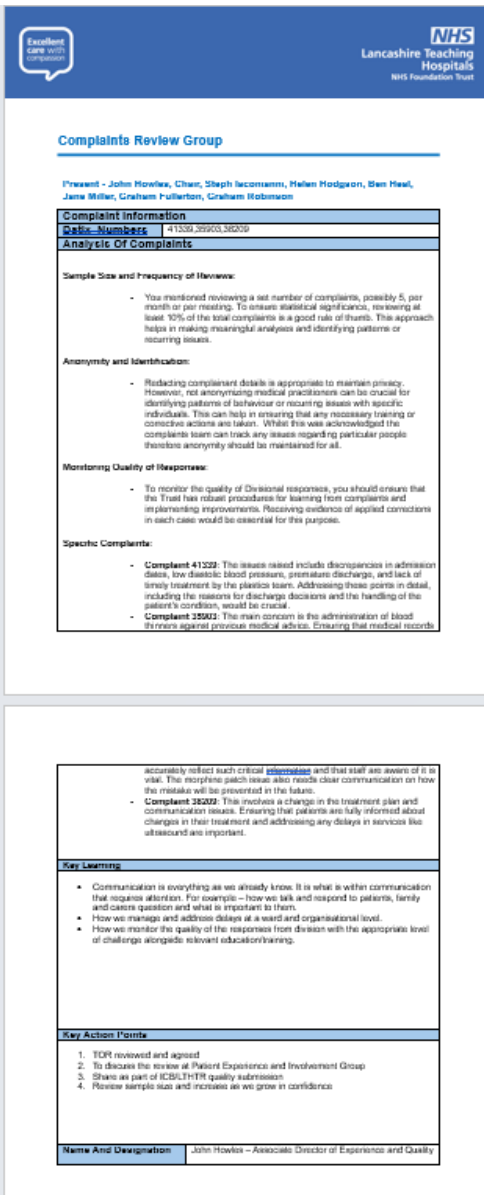
Appendix 1 The Patient Experience and Involvement Strategy 2022 – 2025

Insight			
Year			
Outcome ***Measurement***		**Completed**	**Update**
Driving Improvement	***Year 1*** We will create a dashboard of patient experience and involvement measures. Initiate key programmes of work and define reporting and monitoring arrangements for programmes of work. The dashboard will triangulate feedback sources e.g. themes from complaints, Friends and Family test, patient surveys to keep focus on our key areas of improvement ***Year 2*** We will use intelligence from the patient experience and involvement committee to inform improvement priorities for the Micro-system Coaching Academy (MCA). ***Year 3*** We will review and refine the approach. We will deliver the improvement programme	Complete	The dashboard is available via the bi portal for all staff. It is part of the overarching governance Dashboard. Image 1 below is an example of the Dashboard that wards and areas can see. The dashboard is discussed and shared at MCA training via Associate Director of Experience and Quality. Thus, enabling all participants has access to data as part of their MCA project. The dashboard allows a snap shot in time for ward areas to review all patient experience data and focus on key themes for their ward or area. Image 1 

Section	Group	Indicator	Calc	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Patient Experience & PALS	Complaints by Subject (Based on Subject Location fields)	_Admission/Transfer/Discharge	h	6	4	2	5	7	11	7	3	2	4	7
		_Allegations Against Staff	h	2	1	0	0	0	0	0	0	0	0	0
		_Appointments	h	3	3	4	1	5	0	2	2	1	3	9
		_Diagnostics	h	0	1	2	1	0	2	0	1	2	4	5
		_Complaints Handling	h	0	0	0	2	0	1	3	0	0	0	0
		_Consent, Confidentiality or Communication	h	0	6	0	7	0	1	7	1	0	0	7
		_Clinical Assessment (investigations, images and lab tests)	h	5	1	7	7	7	9	3	5	2	1	9
		_Diagnosis	h	10	5	5	1	4	7	4	7	5	7	4
		_Discrimination	h	0	0	0	0	0	0	0	0	0	0	0
		_End of Life Care	h	2	0	3	1	0	1	0	1	1	1	1
		_Financial Loss	h	0	0	0	1	0	1	0	0	0	3	1
		_Infrastructure or resources (staffing, facilities, environment)	h	9	2	0	3	0	5	3	6	4	1	0
		_Maternity/Labour/Delivery	h	1	1	0	0	0	0	0	0	0	3	6
		_Medical Devices/Equipment	h	0	0	2	2	0	0	0	1	1	0	1
		_Medication	h	3	5	4	4	6	8	8	7	9	5	8

	identified at the end of year 2		
Defining key programmes of work	***Year 1*** We will define key improvement (top 5 programmes of work) and initiate Plan-Do-Study-Act (PDSA) cycles on leading patient experience programmes of work. ***Year 2*** We will evaluate outcome of the PDSA methodology, refine and apply to next set of key programmes of work. We will establish a way to capture live feedback that enables services to be more responsive. ***Year 3*** We will design an improvement programme focused on levelling up the clinical areas to the level of the best	Complete	A number of programmes of work have been developed in the last 12 months, some of the key projects have been completed over the are:. • Work with Imperial College London in relation to FFT, which has enabled this to be available across all areas. • Cataract treatments have been brought back into the acute hospital, and developed patient resources including videos and information • Audiology have designed a project to improve appointments • Patient Experience Portal development and rollout • Instigated clinics in the Sahara Centre to help to reduce inequalities. • Improved experience and waiting time for prisoners • Improved outcomes for patients with post-partum haemorrhage from BAME or Ethnic backgrounds • Further Improvements to Gyane Assessment Unit following new build in Gynaecology for women who miscarriage, the development of pictures, wall arts to make the are feel different which ensured that as a trust we listened to service users (through friends and family, complaints) and improved its environment further. We continue to develop programmes through the MCA programmes across the trust. The focus being on patient involvement and diversity of this, ensuring we are wholly inclusive. A member of the Patient Experience and PALS team along with a Volunteer have been gathering live feedback on the wards in relation to boarded or corridor care patients, this has assisted in the principles of local resolution.
Patient experience equality, diversity and inclusion	***Year 1*** We will mandate collection of each protected characteristic to enable the analysis of inequalities and patient experience processes,	Partially completed	We have started to understand the data in regards to health inequalities and commenced work to capture this. The trust has developed ‘Our Health Plan’. The trust electronic patient record system does have the ability to capture this information although it is reliant that the areas are ‘switched on’ in order to gather the data. Work also needs to take place with colleagues asking patients for this information in line with the NHS Accessible Information Standard. The trust internet and intranet has allows for information to be available in many different languages and formats.

	functions and outcomes. We will organise reports within the organisation to enable teams to review data through the eyes of people with protected characteristics developing a road map for year 2. ***Year 2*** Based on year 1 of analysis, we will identify key priorities within each area based on protected characteristic data. We will expand the definition of protected characteristics to include Indices of multiple deprivation analysis. ***Year 3*** We will demonstrate improvements in identified areas of inequalities based on year 1 and 2 analysis and programmes of work.		The CIVICA Friends and Family system reports on the information that we provide and this is how we will realise this objective. It does now have access to patient emotions which gives the ability to review feedback from different ethnic groups. A road map has been developed as part of 'Our Health Plan', which has provided data from across central Lancs, looking at age, sex, deprivation and ethnicity, as seen in image 2 below: Image 2: 
Thematic analysis	***Year 1*** We will carry out a thematic analysis of patient complaints and concerns to be undertaken in each division, using the outcomes to	Complete	A quarterly deep dive is undertaken and presented to the Patient Experience and Involvement group (PEIG). This looks at information from complaints, concerns and enquiries from patients as mapped in the Datix Governance system. A quality patient experience report is produced by each division and presented at PEIG. The feedback allows for new themes which leads to development of further actions, improvements and learning.

	inform areas of focus to improve patient experience. We will use this to understand gap where there may be an under-representation of feedback and consider opportunities for feedback in the patient's journey (for example mental health). ***Year 2*** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme. ***Year 3*** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme.		Complaints Review Group commenced to check quality of responses and pick up any themes  Excellent care with compassion NHS Lancashire Teaching Hospitals NHS Foundation Trust **Complaints Review Group** Present - John Howles, Cheer, Steph Iacomanni, Helen Hodgson, Ben Heal, Jane Miller, Graham Fullerton, Graham Robinson **Complaint Information** Datix Numbers: 41339,39903,38209 **Analysis Of Complaints** Sample Size and Frequency of Reviews: - You mentioned reviewing a set number of complaints, possibly 5, per month or per meeting. To ensure statistical significance, reviewing at least 10% of the total complaints is a good rule of thumb. This approach helps in making meaningful analyses and identifying patterns or recurring issues. Anonymity and Identification: - Redacting complainant details is appropriate to maintain privacy. However, not anonymizing medical practitioners can be crucial for identifying patterns of behaviour or recurring issues with specific individuals. This can help in ensuring that any necessary training or corrective actions are taken. Whilst this was acknowledged the complaints team can track any issues regarding particular people therefore anonymity should be maintained for all. Monitoring Quality of Responses: - To monitor the quality of Divisional responses, you should ensure that the Trust has robust procedures for learning from complaints and implementing improvements. Receiving evidence of applied corrections in each case would be essential for this purpose. Specific Complaints: - **Complaint 41339:** The issues raised include discrepancies in admission dates, low diastolic blood pressure, premature discharge, and lack of timely treatment by the plastics team. Addressing these points in detail, including the reasons for discharge decisions and the handling of the patient's condition, would be crucial. - **Complaint 38903:** The main concern is the administration of blood thinners against previous medical advice. Ensuring that medical records accurately reflect such critical interventions and that staff are aware of it is vital. The morphine patch issue also needs clear communication on how the mistake will be prevented in the future. - **Complaint 38209:** This involves a change in the treatment plan and communication issues. Ensuring that patients are fully informed about changes in their treatment and addressing any delays in services like ultrasound are important. **Key Learning** - Communication is everything as we already know. It is what is within communication that requires attention. For example – how we talk and respond to patients, family and carers question and what is important to them. - How we manage and address delays at a ward and organisational level. - How we monitor the quality of the responses from division with the appropriate level of challenge alongside relevant education/training. **Key Action Points** 1. TOR reviewed and agreed 2. To discuss the review at Patient Experience and Involvement Group 3. Share as part of ICB/LTHTR quality submission 4. Review sample size and increase as we grow in confidence **Name And Designation** John Howles – Associate Director of Experience and Quality
Friends and Family feedback	***Year 1*** We will ensure all departments are actively participating in friends and family. We will increase the number of ways that patient can provide feedback including paper and other languages and	Complete	10% increase achieved and with a further 4.7% increase in year 3. The divisions have become more invested in seeking the views of patients and are actively requesting access to the CIVICA Friends and Family (FFT) feedback system. Guides are in place to support department managers and training is available as and when required. There has been a sustained increase in the volume of responses for the FFT feedback with the paper surveys. The SMS text and online surveys provide users with the options to complete in different languages, however to date none of the service users have opted for this. Year 3 has seen a 4.7% increase with the FFT feedback for the year 2024-25. This is an increase of 28% in Friends and Family Responses since 2022/23.

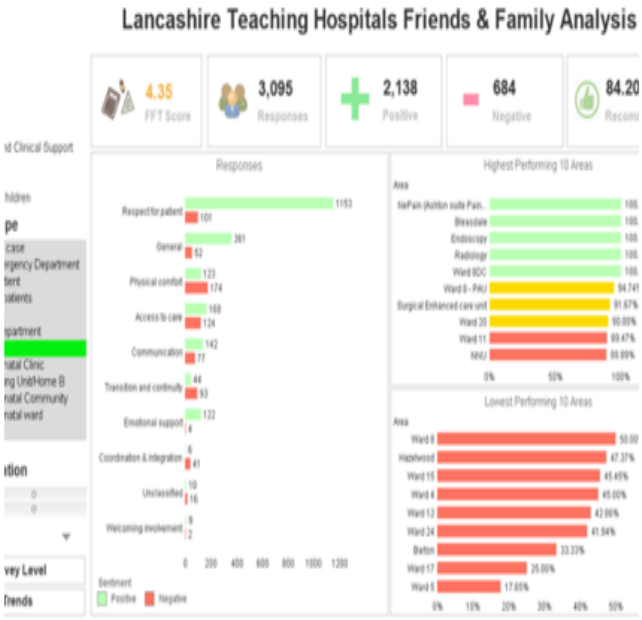
<table>
<tr>
<td></td>
<td>acting upon the responses.

Year 2
We will increase by 10% the volume of feedback from Friends and Family looking at maximising ways to do this and acting upon the responses.

Year3
We will maintain the increase in friends and family feedback acting upon responses.</td>
<td></td>
<td>
<table>
<tr><th>Year</th><th>QR codes/online surveys</th><th>Paper surveys</th><th>Telephone surveys</th><th>SMS text surveys</th><th>Total</th></tr>
<tr><td>2022 - 2023</td><td>2,905</td><td>6,788</td><td>4,421</td><td>37,070</td><td>51,184</td></tr>
<tr><td>2023 - 2024</td><td>3,016</td><td>10,944</td><td>2,112</td><td>46,471</td><td>62,543</td></tr>
<tr><td>2024 - 2025</td><td>973</td><td>13,661</td><td>910</td><td>49,936</td><td>65,480</td></tr>
</table>
</td>
</tr>
<tr>
<td>Patient Experience Culture</td>
<td>Year 1
We will establish baseline measurement of patient experience culture triangulating information from surveys and patient feedback (including information communicated through patient forums).

Year 2
We will agree how to measure culture in relation to patient experience.

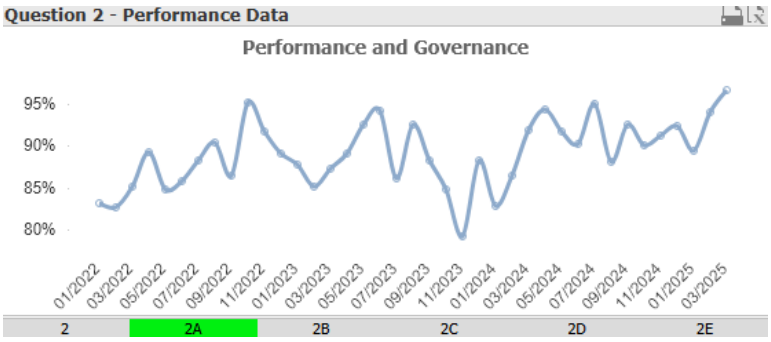
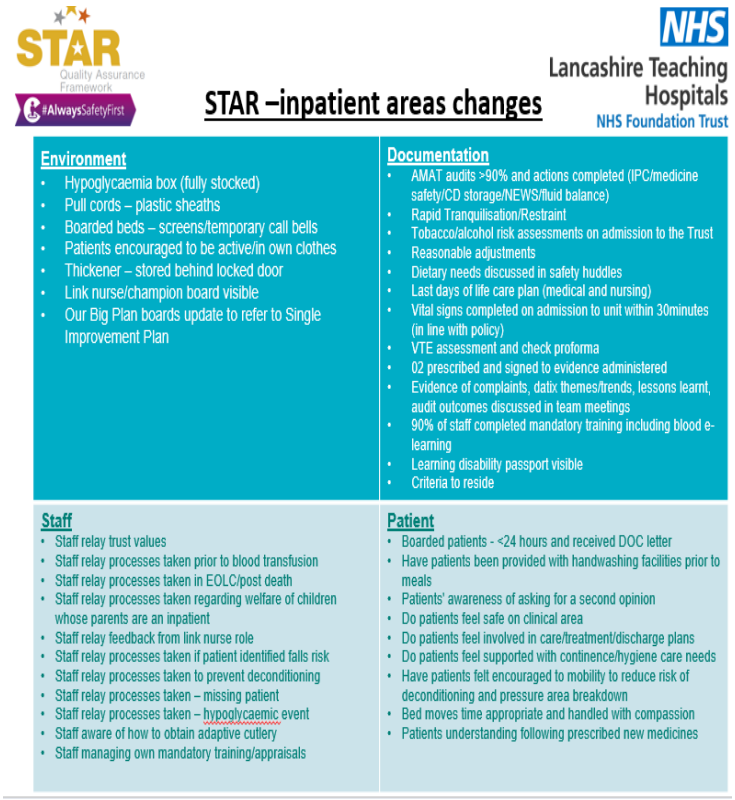
Year 3
We will repeat and embed learning from the feedback</td>
<td>Partially completed</td>
<td>Across the trust there has been a number of independent culture reviews and although we have developed a number of tool kits and we continue working with the Organisational Development team to produce a culture dashboard.</td>
</tr>
<tr>
<td>Research</td>
<td>Year 1
We will participate in</td>
<td>Complete</td>
<td>In year one, organised the infrastructure to test this approach, however in the last 12 months, we are developing that all teams have access to the locally developed dashboard. This dashboard is</td>
</tr>
</table>

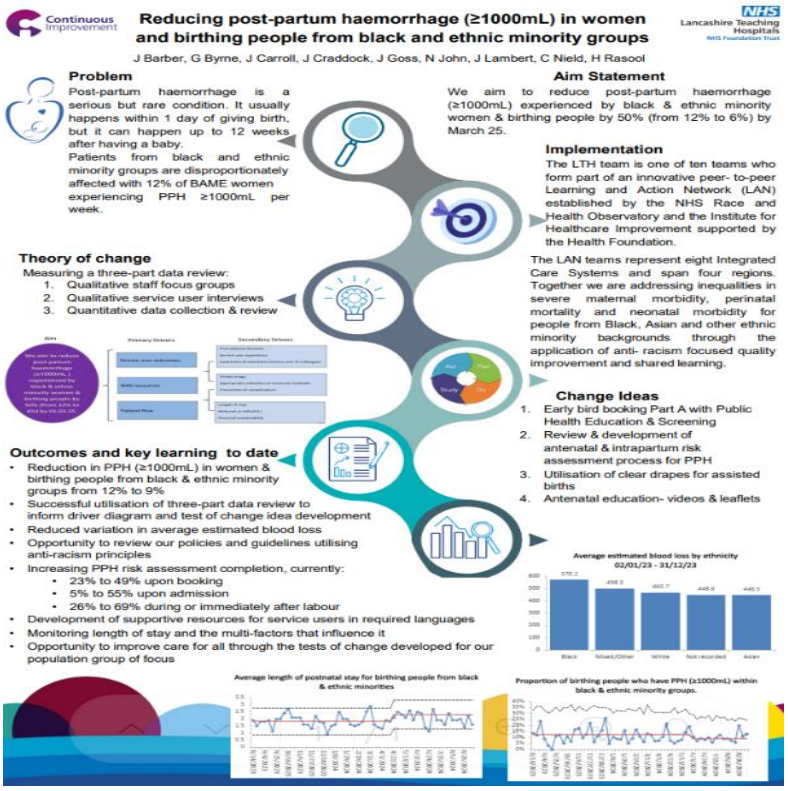
	The Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. As a Phase 1 site, we will collaborate and test the use of natural language processing of free text specifically on patient experience feedback. ***Year 2*** We will continue to participate in the Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. In collaboration with the Phase 1 and 2 sites, refine and innovate to develop intelligence and insights provided by the digital advances testing the approach through continuous improvement methodology.		available on the Business Intelligence (BI) Portal (QlikView) and displays both thematic responses and allows the teams the ability to drill into patient level feedback. This will work in line with the Governance dashboard.  .

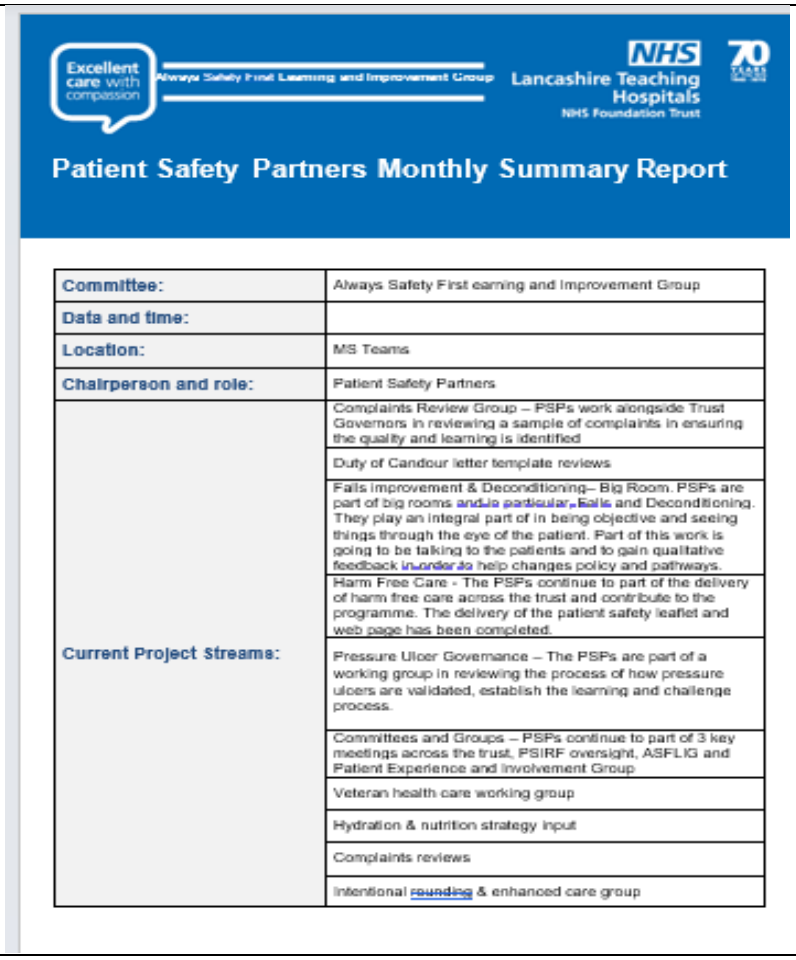
	We will proactively seek to be involved in research relating to patient experience. ***Year 3*** We will repeat and embed learning from the feedback		
National patient experience surveys	***Year 1*** We will ensure that results of each of the national surveys learning to be presented to Patient Experience and Involvement sub-committee and Safety and Learning Group to broaden opportunity to learn and develop action plans in response. ***Year 2*** We will ensure delivery of the actions agreed in response to the National patient experience surveys. **Year 3** We will evaluate the success to date and plan and deliver the work programme for year 3	Complete	All National surveys have been presented to the PECIG and to the Trust Safety and Quality Committee. These reports contain data regarding patient feedback and performance comparted to both local and national trusts. The surveys gives patient feedback on nationally set questions and commissioned by the CQC. It is vital for improvement action plans for each of the departments. The surveys demonstrate: • Cancer Care - Improvements in many metrics • Maternity - Sustained performance • In -patients - Deterioration in patient feedback and comparators • Urgent and Emergency Care – Deterioration in patient feedback and comparators All survey has developed actions plans that are presented at Patient , Carer, Involvement and Experience group monthly.
	Year 1 We will benchmark national survey and Benchmarking Standard responses to peer	Complete	The national Surveys are benchmarked against local and national trusts. This year it has been acknowledged a deteriorated position in both Urgent and emergency care and National Inpatient survey Division have developed Action plan which are monitored through patient, carer experience and involvement group. Focussed assurance held by Associate Director of Quality and Experience

	organisations to learn from what is working well elsewhere and strive to improve the national ranking position. ***Year 2*** We will incorporate learning from peer organisations into Trust action plans and aim to improve the national ranking position. ***Year 3*** We will evaluate actions to date and aim to improve the national ranking position to the next best quartile		within Divisional leads and specialist areas on a bi-weekly to ensure progression. We have reviewed other surveys results and reached out to local and national trusts to enable shared improvements to Urgent and Emergency care.
Improving patient experience communications	***Year 1*** We will link with the communications teams to ensure that key lessons learned from thematic analysis of patient feedback is cascaded across the organisation and externally. ***Year 2*** We will develop sources of communication to ensure that learning is far reaching and evaluate the approach. ***Year 3*** We will re-evaluate lessons learned and modes of	Complete	Associate Director of Patient Experience and Quality meets with the Director of Communications and Engagement monthly, regular updates and learning are added to health matters and other communications updates. Learning from concerns and complaints is published in the governance Learning to Improve bulletins. Increase articles within the trust health matters and social media Presentation at community of practice in relation to Family liaison role and responsibility. Compliments are published monthly in Trust communications to maintain momentum of recording. A 'how to record' video has been produced to assist staff.

	communication to continue to reiterate key messages		
	Year 1 We will link with the Always Safety First Committee to ensure that key patient experience themes related to safety are incorporated into the Always Safety First Bulletin and be physically displayed throughout key public areas of the organisation demonstrating a transparent approach to learning from safety within the organisation. ***Year 2*** We will ensure that learning from Always Safety First will be evident throughout the organisation, with case studies and teams celebrating the successes of the programmes. ***Year 3*** Teams will be supported to gain national recognition for their achievements	Complete	Whilst this group was operational, deep dives were presented to the Always Safety First (ASF) committee quarterly and monthly to the Safety and Learning group. Introduction of PSIRF has enabled a defined role in patient engagement with the family liaison roles. The patients, family involvement in setting terms of reference and presence throughout the reports is improving. The development of PSIRF oversight panel has enabled scrutiny of patient experience data inclusive of complaints, concerns and enquires. Compliments are celebrated monthly in both the trust communication and the Nursing Midwifery, AHP group.
	Year 1 We will ensure that colleague and patient experience feedback is	Complete	The development of Patient Champions across the Trust, most wards and areas have patient experience displays and boards that contain 'You Said, We Did' information based on the results of the FFT feedback. STAR monitors patient experience feedback as part of the accreditation visits.

	displayed in all areas. ***Year 2*** We will evaluate the display of patient experience feedback and improve if and where necessary. ***Year 3*** We will re-evaluate lessons learned and modes of communication to continue to reiterate key messages		STAR monthlies check the 'you said we did' and ask about actions taken. Q2– Performance and governance boards will be updated: 
STAR accreditation	***Year 1*** We will review the patient experience metrics embedded within the STAR process. We will reintroduce Governors to be involved in the STAR accreditation visits to enable real time patient feedback. We will collate themes and trends from patient experience measures to inform opportunities for improvement. Plans will be monitored. ***Year 2*** We will evaluate actions and improvement in response to STAR accreditation	Complete	Patient metrics are reviewed as part of STAR visits, governors have joined the visits. A yearly review of questions has occurred to feedback any themes and is presented at the monthly Nursing, Midwifery and AHP Operational Board (NMAHPB). Star monthly report and Action plan is presented at NMAHP board on a monthly basis 

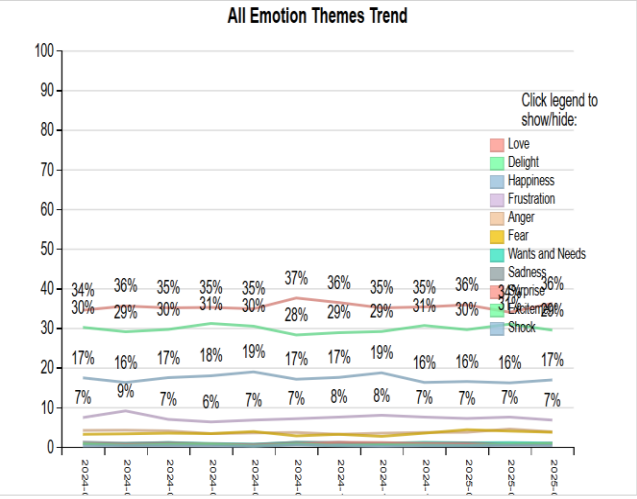
	visits, re-evaluate questions and actions agreed. ***Year 3*** We will continually learn from thematic analysis from STAR accreditation process to inform actions and learning.		
Seldom Heard groups	***Year 1*** We will define those at highest risk and agree the approach to collecting feedback on what matters to the people in these groups. We will seek new ways to collect insights from groups that are less heard. ***Year 2*** A programme of improvement work will be created for these groups to spread learning across the organisation. ***Year 3*** We will build on the new insights and agree year 3 actions with the evolving sources of feedback	Partially completed	Still not achieved the feedback from national surveys or Friends and Family from groups we do not hear often from, links have been forged with some forums and groups and also working with CIVICA to see how we can improve this. To continue to work on improving our data and work alongside the development of 'Our Health Plan' to progress hearing from patients with a protected characteristic. Acknowledging we have made some progress for example work with prisoners and maternity services. 
Equality Quality Impact Assessment	***Year 1*** We will review the policy to ensure EQIA are undertaken in partnership with patients and the results	Partially complete	EQIA process is now well established across the Trust however there is remaining work required to improve the involvement of patients within this process. The recruitment of new Patient Safety Partners (PSP) involved in a number of work streams across the trust which is supporting the voice of the patient.

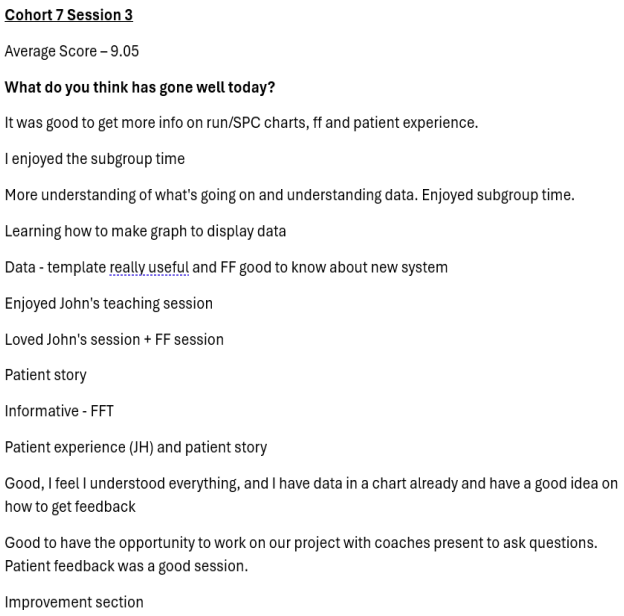
	are meaningful and apply to all change projects. ***Year 2*** We will develop a mechanism for sharing the outputs of EQIA processes to broaden insight in all divisions on patients views and feelings on change proposals. ***Year 3*** We will routinely access patient views and have mechanisms in place in all divisions to do so in an inclusive way.		

Involvement		
Year		
Outcome	**Completed**	**Update**

Measurement			
Patients, carers, families and lay people as partners in safety	***Year 1*** We will align with the Always Safety First strategy and recruit to the role of Patient Safety Partners (PSP) representative of the community we serve. We will ensure that the PSP will reflect the diversity of the community we serve. ***Year 2*** We will take feedback from the PSP to review the Always Safety First year 1 and ensure year 2 reflects the areas that are important to them. **Year 3** We will evaluate the PSP role and identify priorities for delivery in year 3	Complete	PSP have been recruited although at present they are not reflective of the community we serve however there is a planned approach to increase the numbers of these. PSP's are working across a number of groups and have started to have an impact. It should be noted that this role is still in its infancy and development of the role and impact are a work in progress.
	Year 1 The PSP will join the Always Safety First subcommittee and participate in the evaluation of evidence and design of solutions focusing on what matters to patients. We will recruit a senior midwifery advocate. ***Year 2*** We will create a network of advocates and Patient Safety Partners across the organisation to share experiences across specialties. ***Year 3*** We will take the learning from year 1 and 2 and agree year 3 with the Patient safety Partners and senior Midwifery advocate.	Complete	PSP have joined the PSIRF oversight panel, Always Safety First Learning group and PEIG. They are also supporting improvement groups across the trust. Key learning is to ensure the PSP are a true representation of our communities moving forward.
Leadership	***Year 1*** We will define the role of leaders within the organisation in relation to patient experience and involvement and working with patients as partners. ***Year 2*** We will ensure that Leaders at every level of the	Complete	This is developing as we see the role of PSP progressing although this remains in its early stages. Working on how we extrapolate the information and skill mix from annual appraisal. The development of FCA and MCA training across the trust has allowed for a number of staff to develop their leadership skills.

	organisation will have an objective linked to improving patient experience as part of their annual appraisal. ***Year 3*** We will evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities.		
	Year 1 We will commit that all clinical areas will identify patient experience and involvement champions. The champions will continue to work with existing mental health, safeguarding and learning disability champions. ***Year 2*** Representatives from the champions will be present to share their view at the patient experience and involvement group. ***Year 3*** We will evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities.	Complete	Over 170 patient champions across the trust and continue to work across all areas and specialities and attend to share there experiences at the PCEIG. Patient Stories from champions presented PCEIG The effectiveness of the champions is noted with the increase in attendance at the PECIG, the improvements and increase in Friends and Family and the reduction in formal complaints across the trust.
	Year 1 We will increase ward leadership in wards greater than 28 beds in recognition of the challenges of managing large clinical areas. ***Year 2*** We will commit to evaluating the impact on patient experience and involvement that having 2 leaders on large wards has made. Year 3 We will embed the learning from the evaluation once we understand the impact made on experience and involvement having 2 leaders has made	Complete	All large wards have 2 ward managers are in place on them. This is reviewed twice yearly as part of the staffing reviews and Divisional Improvement Frameworks (DIF's). Annual and BI-annual staffing reviews presented at Quality and Safety Committee.
Patient experience and involvement training	***Year 1*** We will agree a training programme and hierarchy of training needs. ***Year 2***	Complete	A blended learning package has been developed for PALS concerns and the need for teams to locally resolve concerns. A complaints handling module was completed this year and aimed at those managers who are required to respond to complaints.

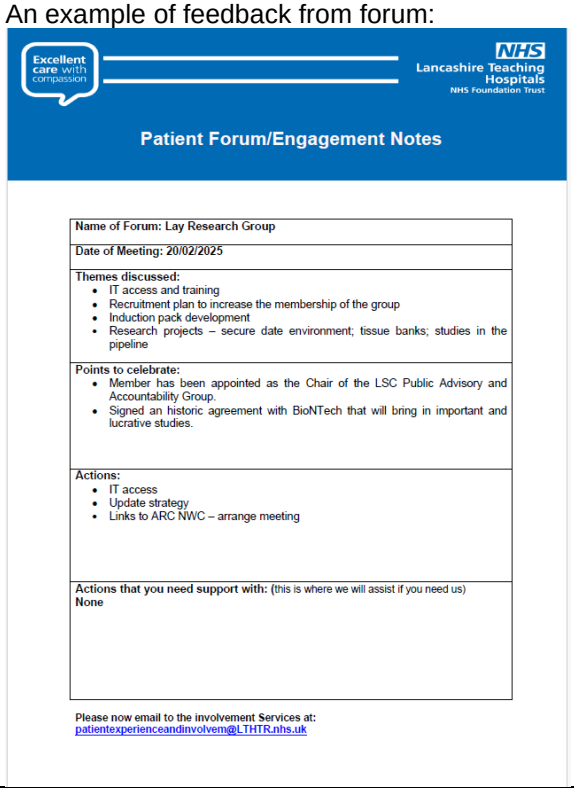
	We will train all clinical and non-clinical department managers as per the training requirements. **Year 3** We will monitor the training plan at departmental level.		A further development is to add the training to the TNAs of teams which is currently being worked through.
	Year 1 We will develop leaders aligned with our Organisational Development programme so that living the values is directly linked to patient experience front and centre in all that we do. ***Year 2*** We will showcase leaders who are creating cultures focussed on patient experience. ***Year 3*** We will continue to showcase leaders who are creating cultures focused on patient experience.	Complete	Work continues in ensuring a focus is given to this a numerous areas, NMC , Civility campaign, patient board stories. External review and internal culture reviews have been presented to Quality and Safety Board. Patient Experience data in relation to emotions is shared at Raising Concerns group 
	Year 1 We will develop a training module for leaders to understand the principles of local resolution, concern and complaints and how to respond. ***Year 2*** We will achieve training for leaders by 50%. We will ensure this training is implemented and evaluated for effectiveness. Year 3 We will further increase training for leaders by 50%. We will continue to embed training and evaluate contribution to improving patient experience during annual appraisal	Partially Achieved	A blended learning package has been developed for PALS concerns and the need for teams to locally resolve concerns. A further module for complaints handling is completed and will be aimed at those managers who are required to respond to complaints. 529 staff completed PALS module 237 staff completed complaints module

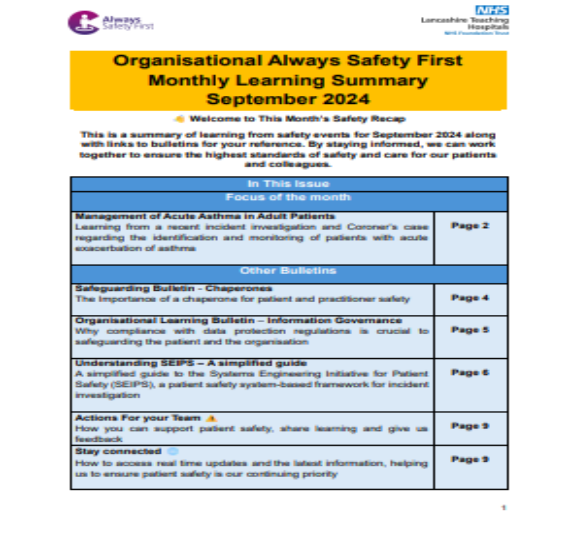
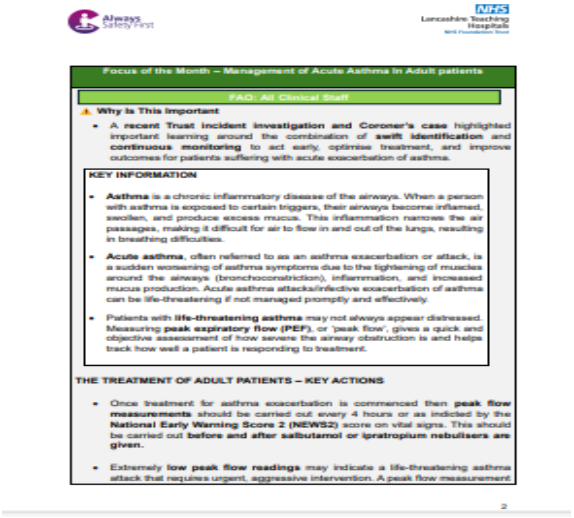
	Year 1 Training in co-design will be identified, this will be delivered through FCA and MCA programmes.. ***Year 2*** All clinical departments will participate in improvement via FCA and MCA and embrace the patient co-design work. ***Year 3*** Evaluate the impact of MCA and FCA participation on patient experience	Complete	Associate Director Quality and Experience attends the MCA to ensure co design is demonstrable. All 8 of MCA ensuring a large number of areas have participated with education regarding patient experience and how they can use this within there projects Feedback from MCA course regarding patient experience session and core to projects. Feedback from one of the cohosts is in image below:  **Cohort 7 Session 3** Average Score – 9.05 **What do you think has gone well today?** It was good to get more info on run/SPC charts, ff and patient experience. I enjoyed the subgroup time More understanding of what's going on and understanding data. Enjoyed subgroup time. Learning how to make graph to display data Data - template really useful and FF good to know about new system Enjoyed John's teaching session Loved John's session + FF session Patient story Informative - FFT Patient experience (JH) and patient story Good, I feel I understood everything, and I have data in a chart already and have a good idea on how to get feedback Good to have the opportunity to work on our project with coaches present to ask questions. Patient feedback was a good session. Improvement section
	Year 1 We will support all staff and students with a booklet about our Involvement services for patients, carers and our community. ***Year 2*** We will increase access to this information ensuring colleagues can access the involvement booklet via clinical practitioners, induction, QR codes and our staff intranet. ***Year 3*** We will maintain and update the Involvement booklet via our Patient Experience and Involvement team.	Complete	Patient Information Group with patients, support staff with all leaflets, posters and QR codes are available. This group provides assurance to the PCEIG in regards to number of leaflets reviewed and the noted feedback for both inpatients and cancer services. All ward communication and involvement booklets updated. As part of the STAR accreditation process it is checked that all ward/areas has accessible information. The trust intranet and internet has improved patient experience information that staff and public have access to including patient stories.
	Year 1 We will develop training sessions that have experts by experience co-delivering the training, to ensure learning from the patient, family or carer.	Partially achieved	The development of community of practice days with all senior nurses and AHP's across the trust has allowed for education and training regarding family liaison by using patients at the centre.

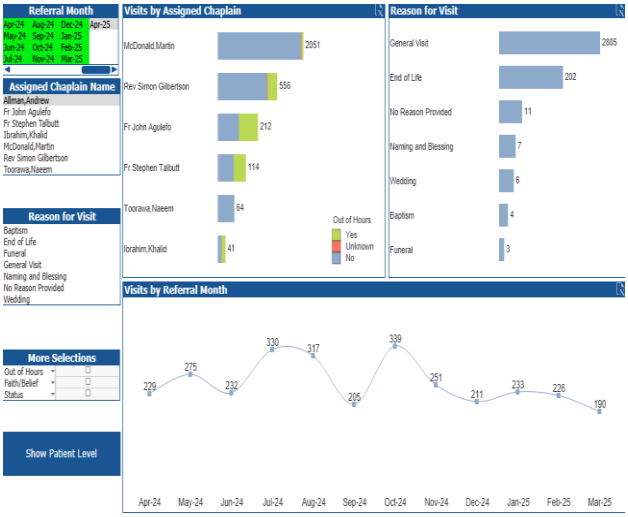
	Year 2 We will continue to develop the training to enhance the skills of our staff to support patients in enhanced levels of care and the use of activity or helpful strategies. ***Year 3*** We will provide training in intersectional approach understanding that no one has just one identity and making sure that one identity e.g. a physical disability is not seen as a stand alone issue.		An example of an agenda below, the richness of the conversation and using patients to support and change practice was palpable. The community of practice has also allowed for senior leaders to role model behaviour, values and show leadership. This does have long term impact on patient experience. Excellent care with compassion **Agenda** NHS Lancashire Teaching Hospitals NHS Foundation Trust **Community of Practice** **Friday 7 February 2025 | 09:30 – 15:00** **Lecture Hall | Health Academy 1 | Royal Preston Hospital** **Topic of the Day: Listening to Patients, Families and Carers** | # | Item | Time | Owner | | | **Arrival 09:00 – 09:15 for a 09:15 start** ****Please register your attendance in Lecture Room 1 – Health Academy 1 – RPH (next to the Lecture Hall)**** **Morning session** | | | | 1 | Welcome to the Community of Practice | 09:15 | Sarah Morrison | | 2 | Icebreaker | 09:25 | Catherine Gregory / Rachel Sansbury | | 3 | Marina's Story (20 presentation + 20 Q&A) | 09:35 | Michelle Young | | 4 | Sharing Good Practice • About Me Boards - Childrens • Pre-op – Reasonable Adjustments | 10:15 | Angela Mason Helen Hoyle / Andrea Hardyman | | | **10:45 Coffee break** ****Tea / Coffee will be served in Lecture Room 1**** | | | | 5 | Handling Difficult Situations | 11:00 | Kate Holt | | 6 | Martha's Rule | 11:45 | Sally Fray / Vicky Wilson | | 7 | What good looks like – Family / Carer / Patient Liaison | 12:00 | John Howles | | | **12:30 Lunch Break** ****Tea / Coffee will be served in Lecture Room 1**** **Afternoon session** | | | | 8 | Break out workshops – HA1 • Meeting Room 2 / Seminar 3 / Seminar 7 / Seminar 8 | 13:00 | Facilitated by DNDs, Deputies, Chief AHPs and Deputy CNOs | | 9 | Feedback | 14:00 | All | | 10 | Setting our Commitments to Practice | 14:30 | All | | | **15:00 Close** | | | **Next meeting: Tuesday 1 April 2025**
Volunteer involvement	***Year 1*** We will create a template and single point of contact for volunteers to give feedback on areas that can improve patient experience and involvement. ***Year 2*** We will ensure that this feedback is acted upon and monitored for improvement. ***Year 3*** We will develop the volunteer service via feedback and learning to continue to improve	Complete	Reports and updates are provided to PCEIG on a monthly basis with relevant feedback from volunteers. Volunteers used to gain patient feedback regularly and present at PCEIG Increase year on year for Volunteers: active 2022 196 active 2023 239 active 2024 318 Over the 3 years this is a 62% increase in volunteers within the trust.
	Year 1 We will recruit a core group of volunteers to work with the patient experience team to enhance involvement and promote improvements. We will ensure full representation of the local diverse community to share their views on services and what matters most to them	Complete	Volunteers in PALS, hospital guides and attendance at a number of local diverse events over the last 2 years, i.e. Windrush, Health Mela, LGBTQ+ events. Hospital guides are in place across both sites Increase year on year for Volunteers: active 2022 196 active 2023 239 active 2024 318

	through the Patient Experience Involvement Group and other annual events, such as PRIDE, Windrush etc. ***Year 2*** We will enhance volunteer training to enable them to support patient experience projects. We will use the feedback from each event to make a commitment to improve an area based on the feedback received. ***Year 3*** We will continue to use feedback from patients/carers to explore and develop projects such as 'Navigation guides' using the volunteer service		
Working in partnership	***Year 1*** We will refresh the organisations approach to "Hello my name is". We will ensure that all staff names are visible to patients. ***Year 2*** We will ensure that "Hello my name is" becomes embedded and is assessed via the STAR process. ***Year 3*** We will continue to promote "Hello my name is". We will continue to assess via STAR process.	Complete	Complete and reviewed through STAR accreditation programme. All staff are required to wear name badges that are visible to patients, along with introducing themselves during care interventions.
	Year 1 We will ask all inpatients what matters to them, and bed boards will be completed holistically and specifically based on the patient's preferences. ***Year 2*** We will ensure that this process is embedded using direct feedback and the STAR process. ***Year 3*** We will evaluate the use of bed boards.	Partially achieved	Use of bed boards is inconsistent but work has commenced to change and deliver this across all ward areas. It is noted that within paediatrics they have developed a new about me board that is being tested which incorporates children and family completing themselves alongside the nurse, the feedback is positive so far.

	Year 1 We will engage with external partners and charities e.g. Galloways, Healthwatch, NCompass and our local Partnership Boards, amongst others via the patient experience and involvement group to be fully inclusive and ensure views and experiences are heard. ***Year 2*** We will review membership and continue to check we are fully inclusive and learning. **Year 3** We will continue to review membership of the involvement group and continue to check we are fully inclusive and learning from lived experiences	Complete	All groups represented on the Patient Experience and Involvement group. This will continue to evolve over time to ensure that new community groups are welcomed to attend meetings. Quarterly meeting held with all community partners . Below in the trust cancer centre hosting the Windrush CEO founder : **Trust's Centre for Health Research and Innovation hosts Windrush CEO and founder** Lancashire Teaching Hospitals' Centre for Health Research and Innovation recently hosted a visit from the Windrush CEO and founder, Adrian Murrell, along with Richard Cupid, who is working with them on their "Race to Health" project. One of the centre's goals is to develop an approach that encourages everyone in our community to participate in our research in a way that is inclusive and welcoming, and in late 2024, we visited the local Windrush Initiatives Team in Preston, a well-established organisation which supports Black and Mixed-Race people in Preston and nearby areas. During this meeting, we introduced our Research and Innovation Department while highlighting that ethnic minority groups are underrepresented in the participants we recruit to research studies. In this latest, follow-up meeting, there was a productive, open, and engaging conversation with the team, which brought up several key points, which you can read here. 
	Year 1 We will agree an approach that engages patients in new developments from their inception. We will continue to promote access to healthcare by events such as 'Our Health Day' for people with a learning disability and / or autism. ***Year 2*** We will ensure that patients views are paramount and heard in all change and new developments using a checklist approach. ***Year 3*** We will ensure that no new projects can be agreed unless it is evident that patient's views have been sought as part of the scoping work		The recommence of the Supported Our Health day for people with learning disabilities, this was an enormous success with may areas supporting the event alongside community colleagues The health mela has been represented by many areas from within the trust over the last 2 years it has recommenced. . All new environmental or patient project such as the new DOSSA build and PEP project all come through PCEIG to gain patient opinions
	Year 1 We will ensure that holistic assessment of patients requirements are made and any reasonable adjustment plans are in place where needed. ***Year 2***	Partially achieved	Reasonable adjustment flag now operational on Harris Flex system and associated training provided. Patient Passports are available for all patients and the Forget Me Not document is available for those patients living with dementia. Both of these support the holistic needs of patients and identify additional needs for care and treatment. Data analysis is work still on going

	We will ensure all staff are trained in Reasonable adjustments on internal systems. ***Year 3*** We will ensure use of data from reasonable adjustments for clarity on our communities' diverse needs		
	Year 1 We will work in partnership to promote shared decision making between disabled people and health services, utilising the Kings fund publication Partnering for inclusion. https://www.kingsfund.org.uk/sites/default/files/2022-07/Partnering_for_inclusion_easy_read.pdf ***Year 2*** We will ensure all chairs of Trust patient forums report and feed into the Patient Experience and Involvement Group. ***Year 3*** We will use new approaches developed through partnering for inclusion to hear more from those less well heard and design improvements for specific groups	Complete	A feedback form is completed from all forums and added for information into PCEIG. A note increase in forums and greater representation from community team at PCEIG Quarterly community involvement meeting held which has enabled further links into the community. This has opened opportunities to reach out and visit areas from some groups that have protected characteristic such as disabilities to bridge a greater understanding of their experience. An example of feedback from forum:  Excellent care with compassion NHS Lancashire Teaching Hospitals NHS Foundation Trust **Patient Forum/Engagement Notes** **Name of Forum:** Lay Research Group **Date of Meeting:** 20/02/2025 **Themes discussed:** • IT access and training • Recruitment plan to increase the membership of the group • Induction pack development • Research projects – secure date environment; tissue banks; studies in the pipeline **Points to celebrate:** • Member has been appointed as the Chair of the LSC Public Advisory and Accountability Group. • Signed an historic agreement with BioNTech that will bring in important and lucrative studies. **Actions:** • IT access • Update strategy • Links to ARC NWC – arrange meeting **Actions that you need support with:** (this is where we will assist if you need us) **None** Please now email to the involvement Services at: patientexperienceandinvolvem@LTHTR.nhs.uk
	Year 1 We will build on current internal patient forums and connect with external partners to make system changes that affect a large number of people most likely to experience inequalities. ***Year 2*** We will agree priorities as a system and work with partners across Central Lancashire to improve	complete	Our Health Plan is now operational within the trust with agreed priorities across central Lancashire. Key messages are seen in the image below: 1: Give every child the best start in life 2: Promote education and life-long learning 3: Ensure fair employment and good working conditions 4: Secure the minimum income necessary for a healthy life 5: Create healthy and sustainable environments and communities 6: Adopt a social determinants approach to prevention and healthy lifestyles

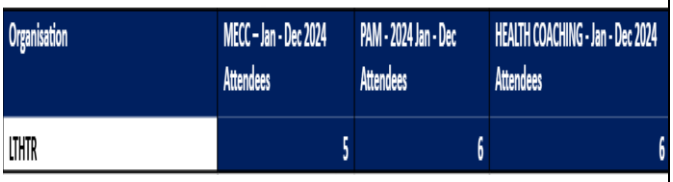
	experiences of those most likely to suffer health inequalities. ***Year 3*** We will encourage collaboration and promotion of projects beneficial to patients and our communities.		
Sharing lived experiences	***Year 1*** We will use narrative, data and lived experience to frame issues and engage towards a shared purpose with staff, patients and carers to improve learning and effect change in team meetings. ***Year 2*** We will have evidence examples of learning from shared lived experiences and provide examples of positive patient experience change as a result ***Year 3*** We will share examples of lived experiences as part of learning bulletins and partnership with patients to improve services	Complete	Patient stories used in a large amount of meetings and we now have a bank on the intranet of stories for staff to see. Development in the Gynae department reconfiguration of the service and estate changed to meet the needs of those ladies who have experienced miscarriage. This was developed as a result of complaints and concerns and co-produced with a family. Patient, care and family involvement has increased and with associated learning bulletins. No greater example than Marinas story.  Organisational Always Safety First Monthly Learning Summary September 2024 Welcome to This Month's Safety Recap This is a summary of learning from safety events for September 2024 along with links to bulletins for your reference. By staying informed, we can work together to ensure the highest standards of safety and care for our patients and colleagues. In This Issue Focus of the month Management of Acute Asthma in Adult Patients — Page 2 Other Bulletins Safeguarding Bulletin - Chaperones — Page 4 Organisational Learning Bulletin – Information Governance — Page 5 Understanding SEIPS – A simplified guide — Page 6 Actions For your Team — Page 9 Stay connected — Page 9  Focus of the Month – Management of Acute Asthma in Adult patients FAO: All Clinical Staff Why is This Important KEY INFORMATION THE TREATMENT OF ADULT PATIENTS – KEY ACTIONS

Engaging with faith leaders	***Year 1*** We will ensure that we listen to what our patients tell us they need in relation to their faith. ***Year 2*** We will continue to ensure representation of all faiths and cultures. Year 3 We will continue to provide information and education support for all staff in the production of guidebooks around culture and faiths	Complete	The Head of Chaplaincy attends Patient Experience and Involvement group and shares relevant patient stories where impacts can be shared. Muslim brethren attend the NMAHP meetings periodically to update in line with the requirements of their faith to raise awareness, for example the requirements of Eid.
	Year 1 We will continue to improve on recognising the needs from patients in all ethnic and religious groups. ***Year 2*** We will use STAR to test the availability of faith resources as agreed in our faith forums. ***Year 3*** We will continue to research and provide staff with support around any additional religious needs that may be required.	Complete	Through the Patient Experience and Involvement group. Food available for a variety of faiths. Supportive and involved with the Rosemere Charity during Eid. STAR covers faith and CARING rounds audit also. 
	Year 1 We will ensure that the bereavement boxes are present on every ward and this is tested as part of STAR. We will acknowledge religious events and ensure that these are treated with respect. ***Year 2*** We will continue to provide and update the Trust Equality Diversity and Inclusion calendar to share relevant religious dates. *Year 3*	Complete	The Trust communications provides updates on religious festivals throughout the year.

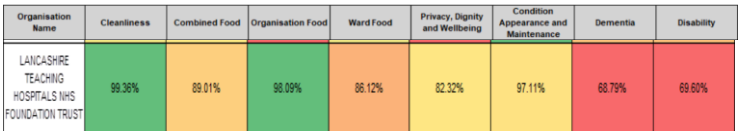
	We will enhance our participation in religious events which will be inclusive of more services such as catering and communications		
	Year 1 We will provide the appropriate faith leader (if requested) to work collectively to deliver end of life care. ***Year 2*** When requested cultures and faiths are respectfully recognised and represented during the patient journey. ***Year 3*** Chaplaincy will ensure multi-faith representation is available	Complete	The Chaplaincy team have a list of all faith leaders within the area and can be contacted at any time should their services be required through our switchboard. Chaplaincy take an active part in CARING walk rounds foe EOL. Chaplaincy provide muliti faith support across the trust on a daily basis where required and sup[port patient, families and carers.
Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient Passports	***Year 1*** We will develop and implement a plan to ensure wards and departments are effectively using tools to enhance patient experience whilst in hospital. We will monitor progress via STAR. We will embed these tools in the role of the clinical area patient experience champions. ***Year 2*** We will evidence increased utilisation of the tools, gathering feedback around their effectiveness. Year 3 We will share examples of the contribution these tools have made to improving patient experience and continue to embed	Partially achieved	The Patient Contribution to Case Notes (PCCN) is sporadically used across the Trust although not embedded. Work is scheduled in year 3 of the strategy to deliver and embed this across all areas. More awareness and emphasis to be placed on the use of the Patient Passport and Forget Me Not documents to ensure all areas are maximising the use of this.

Interpreter services	***Year 1*** We will assess the interpreter service provision for the current service needs to ensure current technology, advice and guidance for staff to access on behalf of patients and their carers. ***Year 2*** We will evaluate interpreter service provision to ensure it maintains fit for purpose. ***Year 3*** We will continue to evaluate interpreter service provision. Interpreter services to be commissioned jointly with patients and carers	Complete	Access available and reviewed regularly. Further awareness of Translation and Interpreter services will be carried out and this information will be refreshed periodically to ensure new members to the organisation are aware of what needs to happen when this service is required. Ward and Area visits in place to support knowledge. All patients whom contact acute settings ie AMU, ED can have immediate access to translation via 3 way communication service.
	Year 1 We will increase recruitment of volunteers who can use sign language. ***Year 2*** We will create a database for volunteers who can use sign language. ***Year 3*** We will continue to recruit volunteers who use British sign language to welcome patients before contracted interpreters are sourced	Complete	British Sign Language (BSL) training has been carried out regularly throughout the last 3 years. This training is open to all staff and training is recorded. Guide Dogs UK throughout 2023 and 2024 - We have provided online sighted guidance 1 hour training sessions for all staff, the course advises the most common eye conditions and the barriers faced by people living with sight loss and explains what we can to do to support people coming into our trust, including those with assistance dogs Compass – throughout 2022, 2023 and 2024 - We have provided 'Bridging the Gap' Deaf awareness 1 hour sessions online that provide information for staff on Deaf awareness and basic BSL. This session covers myths and looks at facts on how best we can support our communities who suffer hearing loss right through to cultural Deaf people. This course has also been attended by invite to our local GP service staff and our volunteers at LTHTR. This course has also promoted free basic level 1 British Sign Language courses which staff have gone on to gain a qualification
	Year 1 We will measure feedback and satisfaction with users of interpreting services. ***Year 2*** We will act upon feedback from users of interpreting services. ***Year 3*** We will continue to evaluate and act upon feedback as part of quality assurance meetings with providers.	Complete	Feedback given, reviewed and continued to be used to ensure positive staff and patient experience. Feedback provided via involvement update ate PCEIG. Language Interpreter services We use Face to face, telephone and video calling services with 2 providers The Big Word: overall it has been consistent over the last 2 years, no increase/decrease as such with on average Face to face 194 jobs per month Telephone 141 per month
	Year 1	Complete	No formal complaints have been received regarding translation and interpreter services.

	We will carry out thematic review of any incident / complaints in relation to interpreter services. ***Year 2*** We will ensure an action plan is in place to respond to learning from incidents / complaints regarding interpreter services. ***Year 3*** We will ensure actions are embedded in practice and continue to evaluate		
Bedside handovers	***Year 1*** We will engage with patients to review our process for bedside handovers, updating policy and maintaining confidentiality. We will consider areas that can be used for confidentiality when discussing sensitive matters or when external assessment is being completed (for example mental health). ***Year 2*** We will audit the process via STAR. ***Year 3*** We will review and re-audit the process.	Partially achieved	This remains inconsistent through audited evidence from the STAR accreditation visits. A standardised approach has commenced through the Always Safety First Learning Group (ASFLG)
Transformation programmes	***Year 1*** We will ensure that patients are involved in co-production of transformation projects ensuring that value added components of the programmes is intrinsically linked to patients value added. ***Year 2*** We will ensure that all transformation programmes have evidence of patient involvement. ***Year 3*** We will ensure that all transformation programmes have evidence of patient involvement and co-production.	Complete	Associate Director of Experience and Quality attends all transformation programmes, stories are recorded and patient voice noted in all meetings. Patient involvement with all new strategies, plan etc as presented at all forums and PCEIG EQIA process for all transformation programmes that are led outside of divisions has oversight from Associate Director of Quality and Experience.
Making every contact count	***Year 1***	Partially achieved	Examples of good practice noted in some areas, this is not shared widely.

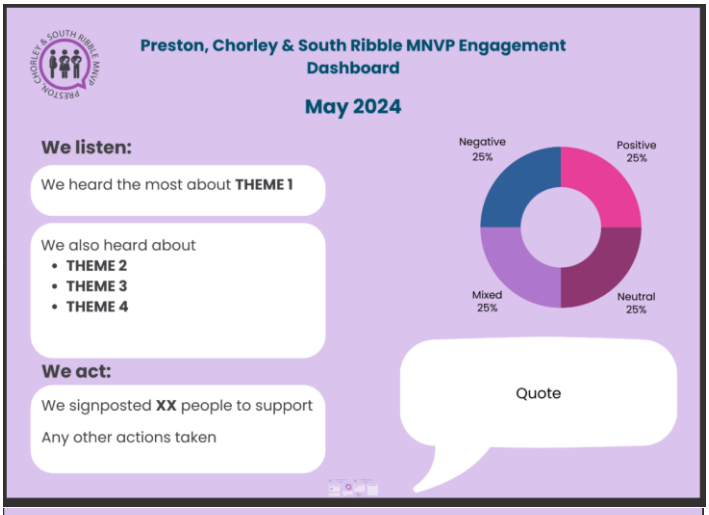
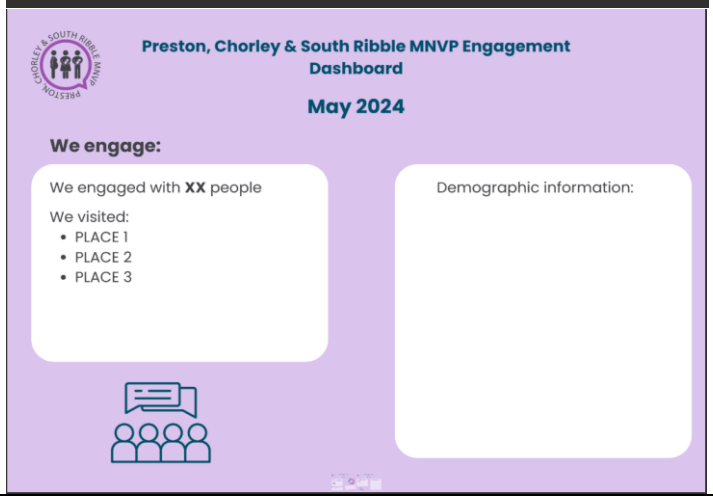
	We will ensure that we take every opportunity to promote healthy lifestyles engaging in opportunities to office advice and guidance around smoking cessation, reducing alcohol intake and promoting healthy lifestyles. ***Year 2*** We will capture health promotion information and discussions on Quadramed. ***Year 3*** We will capture health promotion information and discussions on Quadramed		Ward round document has element s remating to this but remains inconsistent 
Accessible Information Standard	***Year 1*** We will obtain a baseline of current standard that are met and mitigate any gaps creating an action plan towards making health care information accessible to identify, record, flag, share and meet information and communication support needs of patients, service users, carers and patients with a disability, impairment or sensory loss. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/ ***Year 2*** We will review annually in order to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm K compliance with the standard. ***Year 3*** We will review annually to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm compliance with the standard	Complete	The trust internet and intranet meet all accessible standards recommended from a CQC perspective and has been externally reviewed. A indicative tool used by Trusts is Silk Tide's ranking system where we appear at 86% against the A, AA and AAA standards. As a trust we score 2nd highest amongst our ICB partners with LSCFT (92%), ELHT (68%), UHMB (80%), LSC ICB (83%) with Blackpool failing to test. Others in the locality include WWL (72%) and Bolton (61%) and Mersey & WL (69%).
Patient Key Contacts	***Year 1*** We will respond to the feedback from patients with chronic or long term conditions who tell us that they value the role of a key	Complete	An established virtual ward where patients are in their own home and they have a key point of contact for a member of Trust staff to progress their care. CQUIN for decision making in renal and neurology has been completed.

	worker as a point of contact to help navigate and support decision making. We will review what is working well and set this as our standard and benchmark where there are gaps in this provision. ***Year 2*** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this position. ***Year 3*** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this provision.		Introduction of care connexions across the system has supported patients with Key contacts A focussed Discharge action plan developed and supports key patient contacts
Research	***Year 1*** We will continue to raise this profile of involving patients in research by promoting research studies and explaining why involvement in research is important for overall patient experience. ***Year 2*** We will increase the number of patients involved in research and share stories of what this has meant to them and how this has affected their experience. ***Year 3*** We will promote patient experience at research topics for internal degree and masters research topics and share the outcomes	Complete	This is part of the STAR Accreditation process, but we note a couple of research projects: • Work on Postpartum haemorrhage with the BAME community. • Work in neurosurgery regarding spinal surgery and antibiotics Fromer cancer patient who chairs the cancer forum also works in research for the trust and delivers research associated patient stories a to understand the impact and benefits to research. NIHR | Lancashire Clinical Research Facility NHS Lancashire Teaching Hospitals NHS Foundation Trust NIHR | Be Part of Research

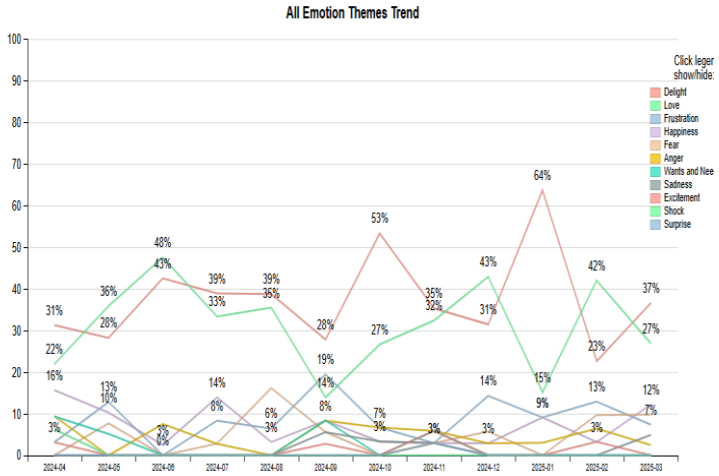
Improvement			
Year 3			
Outcome ***Measurement***		**Completed**	**Update**
Nutrition and hydration and assistance with meals	***Year 1*** We will provide food which is inclusive, tailored to patients needs at the right time, right place and right patient. ***Year 2*** We will measure the quality of provision of catering as a thematic review to establish whether actions taken have led to improvements. ***Year 3*** We will gather feedback and continue to evaluate the effectiveness of actions taken to improve, identifying and responding to new intelligence	Complete	Updated menus are in place including vegan and Halal. The food provision and quality is monitored through the FFT feedback. New digital system foreordering with greater variety for all protected characteristics. Feedback is gained through friends and family test and Facilities present at PCEIG. Further work remains ongoing in relation to food delivery through the Nutritional Steering group
	Year 1 We will celebrate with inclusive food faith events ensuring this is time sensitive when necessary. ***Year 2*** We will improve the rating of food in the national surveys. We will improve the PLACE rating. Year 3 We will improve the rating of food in the national surveys. We will improve the PLACE rating	Partially achieved	National PLACE audit has been carried out this year and feedback provided through the Patient Experience and Involvement group (PEIG). National In-patient survey demonstrated a deteriorated position for food. An associated actin for improvement and work continues through nutrition steering group (FCA big room) PLACE position improved but further work required in certain areas. Food has shown a slight improvement on the previous year 
	Year 1 We will ask you what you want to order and provide	Complete	Digitised menus are now in place and have the functionality to allow more tailored ordering of food. This is monitored through the STAR accreditation visits.

Organisation Name	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	99.36%	89.01%	98.09%	86.12%	82.32%	97.11%	68.79%	69.60%

	you with information so that you can make the right choice for yourself. We will ensure that patients with special requirements have their needs met e.g. such as patients who have Parkinsons and need to eat with medication. This will be tested through STAR. We will ensure all that require support at meal times, receive this and this is tested through STAR. ***Year 2*** We will increase the availability of reasonable adjustments to support nutrition and hydration. ***Year 3*** We will test the effectiveness of this using experts by experience.		Blue trays are available for all patients where additional support with nutrition is needed. Additional needs are identified on the patient behind the bed boards. Increase in availability of food ie Vegan Testing of new foods in relation to menu items iso now in place and staff and patients are used to gain opinions.
Quality Assurance	***Year 1*** We will agree a process to quality assure the responses to complaints and concerns and implement this process. ***Year 2*** We will agree a process to quality assure the responses to complaints and concerns and implement this process. ***Year 3***	Complete	The Complaints process has been reviewed and the Policy updated to reflect the changes in relation to PSIRF. As well as this the Trust policy now mirrors the Parliamentary and Health Service Ombudsman (PHSO) best practice and this is fully embedded. Reviewed process in place regarding quality to assure and monitor how many 2nd responses letters are written. Regularly weekly complaints meetings with the divisions are in place. A process has been established in the Complaints review group which analyses and tests the quality of responses with minutes shared at PCEIG

	We will agree a process to quality assure the responses to complaints and concerns and implement this process		
Maternity and Neonatal Transformation	***Year 1*** We will ensure that women will not feel alone and will treat them with kindness and respect. This will be measured through the national maternity survey. ***Year 2*** We will utilise national initiatives such as the "15 steps" approach and "Whose Shoes?" to review and improve the care provided and environment it is provided in. ***Year 3*** We will continue to gather feedback and evaluate the effectiveness of actions taken to improve the maternity service	Complete	The National Maternity survey showed sustained performance results. The 15 step challenge is in place a led by the Maternity Voices Partnership lead. Continue to gain friends and family data for All Maternity services . Below is an example of testing an engagement board:  
	Year 1 We will make sure that women have the contact details for their midwife. We will ensure that women are able to make a	Complete	A Maternity and Neonates Voices Partnership group is in place. Appointment of Maternity and Neonatal Voices Lead. Badgernet displays contact details of midwife and/ or point of contact. National Directives are discussed and shared at the Maternity and Neonatal Voices meetings. Real focus on Nolan Principles

	personalised care and support plan during their pregnancy, for labour and birth and following the birth of their baby. ***Year 2*** We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership. ***Year 3*** We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership.		
	Year 1 We will ensure women can access help and advice and advice about feeding their babies during their care journey. ***Year 2*** We will ensure breastfeeding areas will be improved across the organisation and in line with the baby friendly initiative. ***Year 3*** We will increase the number of breastfeeding areas will increase. We will increase compliance with baby friendly Initiative (BFI) accreditation.	Complete	Stage 2 Baby friendly Initiative accreditation achieved Lancashire Teaching Hospitals NHS Foundation Trust **Feedback from The UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative Stage 2 Assessment Report for Maternity Services** Received 21st March 2025.

	Year 1 We will seek to receive feedback in addition to Friends and Family and complaints to understand ways in which our services can improve experience for parents. ***Year 2*** We will continue to co-design service improvements. We will upgrade the provision of birthing pools to ensure water births are accessible for all who choose this as a birthing option. ***Year 3*** We will continue to co-design service improvements	Complete	An increase in the amount of Friends and Family feedback has been realised. It also achieved satisfaction in Q1 and Q4 The division are proactively meeting with people who have raised concerns or made complaints to understand how the service and experiences of parents can be improved. The chart below states the patient emotions fro the last 12 months:  The department as repurposed a room following patient feedback to improve the experience of women needing glucose tolerance testing due to the wait they have for the test.
	Year 1 We will involve parents in the co-production of neonatal services utilising the "neonates" group to facilitate this. ***Year 2*** We will become a neonatal network accredited Family Integrated Care Unit (FiCare). ***Year 3*** We will respond to family feedback and focus on improvement in response to their experience	Complete	Neomates are in place to consult with service users. We achieved Green in Family Integrated care Unit for the region which is the highest accreditation.
	Year 1 We will ensure partners can stay	Not achieved	An outdoor space is not in place at present.

	and support women during antenatal periods on the ward. ***Year 2*** We will provide an outdoor space for women in labour that is conducive to the birth process. ***Year 3*** We will identify the next area to improve with our Maternity Voices Partnership.		
	Year 1 We will improve the facilities and experience for women who experience miscarriage. We will participate and achieve accreditation in standard set to support women who have had a miscarriage. ***Year 2*** We will provide an improved baby memorial area. We will provide 7 day bereavement support services. ***Year 3*** We will improve the facilities further for women who experience miscarriage.	Partially achieved	The Gynae assessment unit has undergone a full renovation to improve the experience of patients in the last 18moths. The building works were completed and further art and decals have been supported through the charity to enhance the environment further. A 7 day bereavement service is available and the appointment of a specialised bereavement nurse for woman who miscarriage is now in place again supported by the charity for 2 years The bereavement garden work hasn't commenced to date.

Children and Young People	***Year 1*** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas. ***Year 2*** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor. **Year 3** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor	Complete	Therapeutic activities are in place, e.g. sensory, costumes, themes, books, toys. Father Christmas visits annually. Local football and rugby teams visit for stimulation. Play workers in place and with 2 being trained as play specialist working alongside patient experience lead for area have developed many activities to support children whilst in hospital
	Year 1 We will improve overnight facilities to optimise young people and children's outcomes. ***Year 2*** We will improve review feedback on overnight facilities to optimise young people and children's outcomes. ***Year 3*** We will review feedback on overnight facilities to optimise young people and children's outcomes	Complete	Estates work carried out to improve the environment in paediatrics. Access to better equipment for sleep is available, New about me board tested for Parents and children together with initial great feedback Improvement plan in place and reported into PCEIG Every patient bed on ward has chairs that converts to beds for parents/families
	Year 1 We will ensure that age appropriate activities are provided for 16	complete	All children aged 16/17 are checked on and supported from a Matron as part of their daily checks. A dashboard within BI is in place to give a greater oversight of children in adult wards

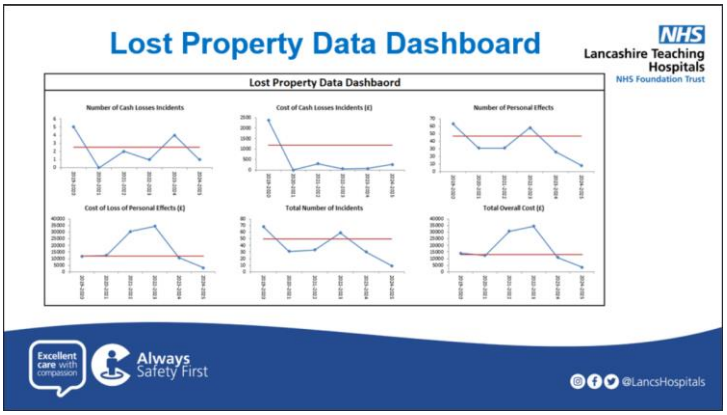
	and 17 year olds being cared for on adult wards. ***Year 2*** We ill ensure that age appropriate activities are provided for 16 and 17 year olds being cared for on adult wards. ***Year 3*** We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards		
	Year 1 We will introduce a parent group to gain feedback and promote co-production in service change. ***Year 2*** We will agree parent priorities to improve and co-design these. ***Year 3*** We will continue to work in partnership exploring the needs of looked after children using social care advocates	Complete	Youth forum in place. Young people form part of the recruitment process which supported the recruitment to a Children youth worker. Work to set up forum in community area of Chorley called Youth zone is also commenced Exploration of community partnership work has also commenced led by the patient experience lead
	Year 1 We will provide a multi-sensory space for children with disabilities at the Broadoaks site. ***Year 2*** We will explore the provision of outdoor play for children on each of our sites. ***Year 3***	Partially achieved	Work remains to be completed for Broadoaks site in regard to outdoor space.

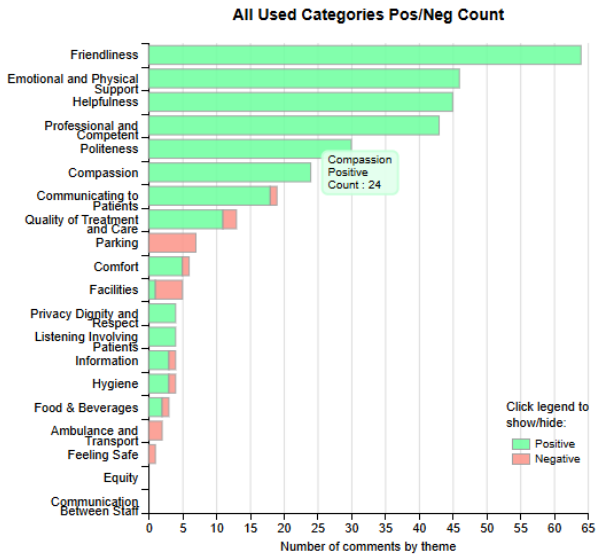
	We will implement increases in outdoor play provision		
	Year 1 We will introduce the role of patient experience lead for children to provide additional support across all areas. ***Year 2*** We will learn from this and adopt the learning to clinical areas where children are seen in across the organisation. Year 3 We will continue to share the learning from the patient experience lead	Complete	Recruitment to lead and supporting the patients with children is in place and an action plan developed with clear objects to achieve which feeds into PCEIG
	Year 1 We will ensure that children and young people have an appropriate process to raise concerns or make a complaint and we will ensure feedback from the Emotional Health Family and Friends Test is collated and reviewed for learning. We will identify a training plan in relation to play for children's ward and ED. ***Year 2*** We will enact the plan and train 50% of the staff in formal play training. We will roll out the process for children to raise a concern to all	Partially achieved	Developed a procedure where children and young people feel comfortable to raise concerns or complaints which is user friendly. Has been developed in conjunction with the Youth Forum and divisional leads. Develop further the voices of children through the Friends and Family feedback. 2 play staff completing Play course and then role out of training, compliance with this is not at the required rate expected, Feedback mechanism for friends and family in place via digital version.  The national Children's survey has recently been released and will be presented at quality and Safety in June.

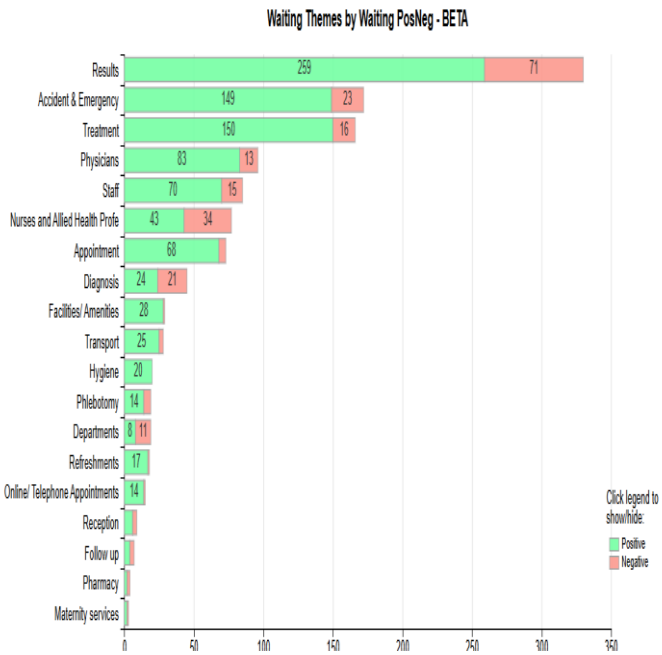
	clinical areas they are seen in the organisation. ***Year 3*** We will monitor the impact of the improvements through the national patient and parent surveys		
Estate	***Year 1*** In recognition of the impact that our estate makes on patient experience we commit to a refurbishment plan for three clinical areas each year. *Year 1* • Gordon Hesling Building entrance – introduction of volunteer support space • Mental health facilities in ED for children and adults • Create an alternative to hospitals for patients who do not meet the criteria to reside ***Year 2*** We will commit to a refurbishment plan for three further clinical areas each year. **Year 3** We will commit to a refurbishment plan for three further clinical areas each year	Complete	All work completed and further refurbishment planned. Further work completed in: • CDH theatres which support children • New AMU supporting patients experience through acute pathway • Endoscopy room increase , which supports delays in • Hyper acute stroke unit developed procedures to ensure seamless care • New health port commenced to support access to services in community
Pain management	***Year 1*** We will focus on improving pain	Complete	Work is on-going with the pain team to improve the patient experience through the FCA big room

	management and test the effectiveness of this through STAR. ***Year 2*** We will share learning from areas that manage pain more effectively ***Year 3*** We will see improvements in national audits relating to pain management.		A new Friends and Family feedback questionnaire has been developed. This is also monitored through the STAR accreditation process. Improved position in regards to pain in surveys Patient stories regarding pain management which is supporting patients with long term pain conditions.
End of life care	***Year 1*** We will continue to use the end of life big room to deliver integrated, collaborative palliative and end of life care and improve patient and carer experience and service outcomes based on principles of respect, dignity and compassion. ***Year 2*** We will explore area to be used for end of life quiet rooms for families. ***Year 3*** Provide quiet areas for families of patients at end of life and for bereaved families.	Partially achieved	A Big room in place and effective for end of life care EOL rooms being worked on and in place in some areas but remains not all wards or areas have them. From learning from patient feedback from experience in emergency department a quiet room has been developed and used well at Chorley. The trust has a bereavement suite available on the RPH site
	Year 1 We will define an increased target audience for advanced communication skills training. ***Year 2*** We will achieve the target set once the audience is reviewed.	Partially Achieved	The trust has successfully transitioned over to PSIRF and with this came an increase in staff trained in engagement training. A caveat to this is that the trained as nationally required has stalled the improved numbers of this. Over 200 staff trained. The commencement of the community of practice events has enabled role modelling and coaching team in relation to communication and its importance.

	Year 3 We will extend the number of people training in advanced communication skills.		
	Year 1 We will embed the CARING model as our pledge to patients in last days of life and their loved ones. ***Year 2*** We will monitor and evaluate CARING through the STAR audit. ***Year 3*** We will continue to evaluate the impact of the CARING approach.	complete	CARING in place in now embedded and carried out across the clinical areas, it has been reviewed and now much more diverse. CARING is part of the STAR accreditation visits.
	Year 1 We will recruit families who have had experiences of bereavement to work in partnership to improve services. **Year 2** We will use the national NACEL audit to drive the areas we focus on improving. ***Year 3*** We will review and set an improvement goal for each of these in year 3	Complete	Patient stories captured and used at board and also the Patient Experience Involvement group. NACEL audit used to influence STAR and monitored through accreditation visits. Improved position with NACEL audits and STAR reflected changes necessary to improve further.
	Year 1 We will deliver in partnership a Hospice at Home service to increase the number of patients who are able to die in their preferred place of care.	Not Achieved	This is not in place at present

	Year 2 We will create the case to formally commission hospice at home pending outcome measures supporting hypothesised benefits. **Year 3** We will deliver in partnership a hospice at home service that meets the need of the local population		
	Year 1 We will ensure bereavement services are available to all who experience loss 7 days per week. ***Year 2*** We will ensure bereavement services are available to all who experience loss 7 days per week. ***Year 3*** We will ensure bereavement services are available to all who experience loss 7 days per week	Complete	Complete and 7 day service in place
Lost property	***Year 1*** We will ensure our processes around patient valuables is robust using patient experiences to build on the procedures we have in place. ***Year 2*** We will ensure our process is established within	Complete	Complete and reduce financial spend noted. 

	all areas and test this using STAR. We will investigate when items are lost and share lessons learned to reduce the occurrence of this. ***Year 3*** We will monitor this service regularly and listen to feedback in order to instil confidence from our patients and visitors to the Trust		
Improve facilities for people while they wait	***Year 1*** We will ensure patients know timescales of any delays in clinical areas. ***Year 2*** We will ensure details are provided of expected wait times and regularly update this information. ***Year 3*** We will monitor wait times in clinical areas and adapt time slots if data shows continual trends of long waits	Complete	Investment provided in a number of areas for example ward 4. Timescales provided in wating rooms. Friends and family feedback from outpatients 24/25:  Time scale for appointment delays are published on trust website. Monitor of delays discussed and reviewed at PSRIF Triage and oversight panel
	Year 1 We will provide comfortable and appropriate seating, that meets the needs of those using it in line with reasonable adjustments. This will be tested through STAR.	Partially achieved	A review of ED seating underway has been undertaken but no progress to improve this to date, new mattress for trolleys in place. A dedicated Nurse to the waiting room is available 24 hours a day. Upgrade to bathroom facilities has been completed. The Urgent and Care national survey action plan is place to support progress this forward

	Year 2 We will ensure that areas that experience long waits such as ED will have access to comfortable environments. ***Year 3*** We will continue to listen to feedback from our patients and develop services.		
Improving patient flow	***Year 1*** We will engage in improvement programmes via the Urgent an Emergency Care transformation board to improve our patient flow throughout the hospital. This will reduce time patients spend in the ED and assessment units and ensure that patients time in hospital is value added and reduce waiting for services that will progress the pathway of care. We will ensure that discharge is well coordinated and occurs early in the day. ***Year 2*** We will continue to monitor our performance and seek out opportunities to continually improve patient flow, asking patients what matters to them. ***Year 3*** We will monitor our outcome measures and	Complete	Being monitored in UEC board and SIP boards with clear measures to monitor this although an acceptance of not where it needs to be. A detailed Discharge action plan is in place and system wider recovery plan for operational flow also in place. Further work is planned in relation to rapid improvement weeks for patients not meeting the criteria to reside. It must be acknowledge the significant operational pressures from a UEC perspective and impact this has happened in relation to patient experience. Below is the positive and negative emotions of patients in the ED department  As a result of this the trust is working further on supportive comfort action for patients waiting within the UEC pathway

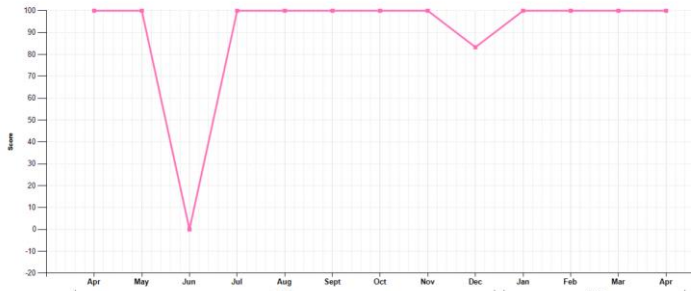
	seek new ways to maintain progress		
Improve patient experience for those living with dementia	***Year 1*** We will promote understanding of our dementia community. ***Year 2*** We will ensure all staff complete dementia training. ***Year 3*** We will continue to educate staff through e-learning packages	Complete	Information on corridors. Dementia Champions who meet regularly. Dementia education package developed on blended Learning
	Year 1 We will ensure purple activity boxes are available to all patients and tested through STAR. ***Year 2*** We will ensure purple activity boxes are available to all patients and updated following patient feedback over the year. ***Year 3*** We will introduce innovative approaches to managing the experience of patients with dementia.	Complete	Activity boxes on wards and tested through STAR. Dementia Strategy presented to PEIG. STAR plans updated following feedback. Commencement of work for patient whom require Enhanced care has begun looking at least restrictive practice and bay nursing.
	Year 1 We will ensure promotion of dementia champions in all clinical areas. We will ensure this Patient Experience Strategy is in line with the Dementia Strategy and progress monitored in	Complete	Monthly catch up's are in place for dementia champions. The DOSA building work has engaged with patients living with dementia. Monthly updates from Dementia lead provided on cycle of business through PCEIG and updates given also at safeguarding board within he cycle of business Training data reviewed at safeguarding board Dementia referrals:

	relation to pathways, the Dementia Experience and Empowerment project (DEEP) and co-production with patients living with a dementia and their families and carers. ***Year 2*** We will continue to promote the use of Forget Me Not passports. We will report progress on the mental health and dementia strategy to the safeguarding board and patient experience group. ***Year 3*** We will report progress on the Mental health and dementia strategy to the safeguarding Board and patient experience group.		<table><tr><td>Year</td><td>Number of ward referrals/clinical contacts</td><td>Notes reviewed-telephone contacts</td></tr><tr><td>2025</td><td>23</td><td>452</td></tr><tr><td>2024</td><td>110</td><td>2117</td></tr><tr><td>2023</td><td>83</td><td>1645</td></tr><tr><td>2021</td><td>63</td><td>N/A</td></tr></table>
Improve facilities for patients with a physical disability, autism, learning disability, mental health condition	***Year 1*** We will continue to promote the use of the Hospital Passport. ***Year 2*** We will ensure a copy of the passport is taken so we can provide specific individualised care. ***Year 3*** We will provide staff with information and updates on sources available through our Patient experience and	Complete	Hospital passport a regularly used across the trust and uploaded to evolve on the trust EPR system. Request to use the passport are suggested through complaint and concerns responses. An update on new information sources and information is updated and provide to PCEIG

	Involvement team.		
	Year 1 We will ensure all reasonable adjustments are recorded on our systems and test the use of this through STAR. ***Year 2*** We will collate data so future appointments can be adapted to the requirements of the patient. ***Year3*** We will evidence increased use of reasonable adjustment tab on Quadramed	Partially achieved	The reasonable adjust flag with a clear policy and guidance challenges extrapolating the data remains alongside linking directly with GP records.
	Year 1 We will ensure staff liaise with the Learning Disabilities team for specialist advice. ***Year 2*** We will require progress with our partners to agree the next set of actions for blind, visually impaired. ***Year 3*** We will evidence an increased number of MDT care planning forums take place leading to improved person centred care	Complete	The number of patients referred to the learning disability teams has increased by 25% from the previous year Referrals - 23/24 – 314 24/25 - 392
	Year 1 We will continue to provide ward activity boxes for partially sighted or blind communities and test this through STAR. ***Year 2*** We will review progress with our partners to agree the next set of	Complete	Complete and monitored through the STAR accreditation visits. Discussed at the Visual Impairment forum to ensure things are in place and guidance given on a number of project over the last 3 years. VI forum attended the Health Mela and Annual members meeting. The VI forum is in progress of setting out some key objectives for the next 12 months to be considered

	actions for blind, visually impaired. ***Year 3*** We will review progress with our partners to agree the next set of actions for blind, visually impaired		
	Year 1 We will continue to upgrade estate with hearing adjuncts in line with best practice and ensure we work with local groups to test the impact of our focus on hard of hearing or deaf communities. ***Year 2*** We will review progress with our partners to agree the next set of actions for deaf and hard of hearing. Year 3 We will review progress with our partners to agree the next set of actions for deaf and hard of hearing	Partially achieved	Working alongside Ncompas and deafways has enable a clear view on what is required and the experiences of patient whom attend. Representation from both is regularly at PCEIG. Not all estate has appropriate facilities in place for the deaf. Good access to language services to support with sign language is in place.
	Year 1 We will engage in the Learning Disability Partnership board and Autism Partnership Board working alongside experts by experience and our multi-agency partners to re-establish a Health sub group. ***Year 2*** We will implement the national learning disability and autism strategy. Year 3 We will implement the	Complete	Strategy developed and in place to support national standards Strategy developed in conjunction with our patients and service users. Our health day recommenced with great feedback

	national learning disability and autism strategy		
	Year 1 We will ensure promotion of the Learning Disability Champions and Mental Health Champions. We will ensure this Patient Experience Strategy is in line with the Mental Health Strategy, the Learning Disability Plan and Autism Strategy. ***Year 2*** We will monitor this through the safeguarding and patient experience and improvement group. ***Year 3*** We will monitor this through the safeguarding and patient experience and improvement group	Complete	Complete and monitored through the Safeguarding Board and PCEIG.
Cancer care	***Year 1*** We will introduce a patient experience lead in Radiotherapy with a focus on improving the experience for patients attending for radiotherapy and establish a service user group. ***Year 2*** We will evaluate the impact that the patient experience lead in Radiotherapy with a focus on improving the experience for	Complete	This post has been recruited into 95% to 100% consistently positive Friends and Family feedback, largely due to open days prior to treatment.

	patients attending for radiotherapy and establish a service user group. Year 3 We will ensure the patient experience lead is embedded in practice.		**Question 1:** Overall, how was your experience of our service? Rosemere Planning Appointment (Radiotherapy)  2024 2025 Hospital / Month Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar Apr All Sites 100 100 0 100 100 100 100 100 83 100 100 100 100
	Year 1 We will establish a cancer patient listening service to gain live feedback from cancer patients and address issues at the time if possible. ***Year 2*** We will explore involvement in addressing the needs and support service users receiving services from different clinical teams e.g. buddying in different services and co-facilitating training with Macmillan Engagement Facilitator to build confidence, skills and knowledge. Year 3 We will involve patients and volunteers to work alongside the Macmillan assistant manager to work with patients in the community and provide care closer to home	Complete	The Macmillan service has delivered service across a number of community service over the last 3 years. The development of clinics inn the Sahara centre screening patient has been successful identifying new cancer • Wok within local Muslim schools regarding taboo topics within the health care • Men's well being checks in the local prison • Breast awareness checks in Asian ladies forums
	Year 1 We will develop a cancer and end of life service user recruitment strategy.	Complete	Complete, public and forum members have supported interviews across trust. The chair of cancer forum now works within research within the trust.

	Year 2 We will continue service users to be involved with the MPACE project and close working with key Macmillan figures. ***Year 3*** We will explore a partnership approach with the third sector to share volunteer opportunities and collaborative working.		The cancer actively take part in MPACE which has helped increase the diversity of the forum. This was closed down Nov 24. The Macmillan service has delivered service across a number of community service over the last 3 years. The development of clinics inn the Sahara centre screening patient has been successful identifying new cancer Wok within local Muslim schools regarding taboo topics within the health care Men's well being checks in the local prison Breast awareness checks in Asian ladies forums
	Year 1 We will provide HOPE course using service users to facilitate the course in partnership with third sector partners. ***Year 2*** We will continue to implement service user involvement in all cancer interviews. We will continue to deliver and promote the HOPE courses for patients with cancer. ***Year 3*** We will ensure Cancer patient and carers forum increases in membership	Complete	Complete and have worked with GP's to promote HOPE course. Cancer forum number increased over the last 3 years. The Hope course is provided at vine house and runs 4/5 sessions (6week Course) and is full all year round. We have cancer forum members whom are facilitators within this course
	Year 1 We will develop a work programme for the promotion of service user opportunities. ***Year 2*** We will increase the diversity of patients and partners. ***Year 3***	Complete	Complete with board stories presented.

	We will develop a process for patients as partners to present to the Board of Directors the progress made in this area		
	Year 1 We will develop a virtual forum for patients and carers to link in when they want and to choose which opportunities they wish to be involved in. ***Year 2*** We will continue to recruit service users for the forum and widen recruitment to the forum for diverse range of services users and carers to include BME, LGBTQ, over 75s, working age, disabilities, from all economic backgrounds etc. ***Year 3*** We will deliver on the areas determined as priority areas for each protected characteristic group.	Complete	Ther a number of forums for both staff and patients. The patients have access to carers and staff has access ambassador for as examples. Recruitment and encourage to forum groups are in a place with information on trust internet. We have recruited to forums from a protected characteristics which has enabled links into the community, such as Sahara Centre
	Year 1 We will develop standard operating procedure, to involve service users in all interviews for cancer staff. We will develop a training package guide for service users to assist in opportunities they	Complete	Complete and service users involved with recruitment. Improvements within the National Cancer services audits demonstrated.

	can be involved in. ***Year 2*** We will evaluate the effectiveness of this approach in partnership with patients. ***Year 3*** We will focus on specialities that evaluate less effectively in the national cancer survey		
	Year 1 We will continue service user involvement with the MPACE project and close working with key Macmillan figures. ***Year 2*** We will test the cancer website against the exemplar and agree the next year improvements. **Year 3** We will celebrate achievements and share the positive areas of practice	Complete	The cancer actively take part in MPACE which has helped increase the diversity of the forum. This was closed down Nov 24. We have trust Cancer intranet page which provided up to information, advice and new projects. A newsletter is also provide and updated. 
	Year 1 We will continue to work with patients in	Partially achieved	Remains under development.

	develop the cancer website. ***Year 2*** We will focus on specialities that evaluate less effectively in the national cancer survey. ***Year 3*** We will continue to focus on specialities that evaluate less effectively in the national cancer survey		
Patient involvement in safe discharge	***Year 1*** We will commence discharge planning from the time patients are admitted to the hospital. ***Year 2*** We will use discharge improvement work to ensure discharge occurs earlier in the day for patients and families. ***Year3*** We will continue to evidence improvement in this area	Complete	Discharge planning commences on admission to clinical area. Commencement of Rapid improvement week focussing patients not meeting the criteria to reside will commence soon.
	Year 1 We will ensure that discharge needs are clearly documented and shared with partner organisations where consent is given, this will reduce the need for patients and carers to repeat needs and wishes to achieve safe discharge. ***Year 2*** We will commit that learning from discharge incidents will be shared and actions agreed.		Complete and on DPD, paper provided to Patient Experience and Involvement group. PSIRF triage review incidents relating to discharge as national priority. Patient safety investigations discussed and analysed.

	Year 3 We will learn from discharge incidents wand this will be shared and actions agreed.		
	Year 1 We will review our patient information leaflet and relaunch this, so it is shared with all patients to ensure a safe discharge. ***Year 2*** We will ensure that the use of the patient information leaflet is tested through STAR. ***Year 3*** We will ensure that use of the patient information leaflet will continue to be monitored.	Complete	Complete and monitored through the STAR accreditation process. A new patient safety leaflet has ben produced and shared with patients on admission 
	Year 1 We will introduce live feedback on the discharge process, this will be used to drive improvement in this area. Wards will be test on this through STAR. ***Year 2*** We will use feedback to change process or information shared. ***Year 3*** We will build a reporting dashboard that tracks and time stamps discharge process.	Complete	Complete and feedback provided through the Friends and Family data. A dashboard has been created for daily discharges and this can we correlated with relevant friends and family feedback. Discharge summary report presented at PCEIG on a cycle of business

	Year 1 We will continue to plan ahead for discharges and ensure where possible discharge letter and take-home medication is on the ward with the patient the day before their planned discharge. ***Year 2*** We will work closely with carers service to better identify informal carers when planning patient discharges and offer onward referral for carers support and assessment. We will fully embed the "nothing said about me without me" principle for all discharge planning discussions. ***Year 3*** We will evaluate the effectiveness of these interventions through the national patient survey	Partially achieved	The data does not currently demonstrate we are achieving significant change to take home or discharge the day before. This has been raised and discussed at the Carers forum and experiences have been shared and demonstrates a deterioration on national in patient survey. Action plan in place. A review of pharmacy STAR process completed Clinical and Supply transformation project are planning pilot of drug counselling QR codes Continuous improvement activities in place to improve the discharge process including increasing prescribing by pharmacists, ward based dispensing and clinical pharmacy technician validation. Patient counselling for key medicines identified as standard and training module being updated to embed. Quarterly survey of patients being established.
	Year 1 We will implement post discharge follow up calls to a minimum of 50 patients per week (within 48 hrs of discharge) who have had an inpatient stay, this will support ensuring they are safe, identify if any unmet needs were missed prior to discharge and ensure signposted or	Partially achieved	We are not compliant although through the PCEIG and Involvement group, a planned approach is to be defined. There is evidence of some speciality involvement with follow calls for patients whom are discharged but it remains inconsistent. Stroke services, home first discharge have a process

	referred for relevant support. We will also gather feedback around their discharge and what could be improved, ***Year 2*** We will include patient representatives on future improvement workstreams internally and across partner organisation improvement work. We will implement using patient feedback changes and improvements to the process, this will be tested through the national patient survey. **Year 3** We will implement using patient feedback, changes and improvements to the process, this will be tested through the national patient survey		
	Year 1 We will have consistent representation at the care home collaborative to understand discharge impact on care and nursing homes with the aim to improve relationships and trust between organisations building further on the trusted assessor model. ***Year 2*** We will demonstrate a	Partially achieved	We are not compliant although through PCIEG , a planned approach is to be defined. There is evidence of some plans in regards to trusted assessor and relationship building for patients discharges to nursing homes but remains inconsistent The development of care connexions has improved relationship also.

	year on year increase in the number of trusted assessments between the regulated care sector. We will evaluate progress on improving discharges with regulated care settings and agree priorities. ***Year 3*** We will evaluate progress on improving discharges with regulated care settings and agree priorities.		
Essential carer role	***Year 1*** We will introduce the essential carer role into a small number of adult inpatient test sites and evaluate the effectiveness using Plan, Do, Study, Act (PDSA) cycles. ***Year 2*** Following evaluation of the test sites we will role this out to all wards in order to meet patients needs. ***Year 3*** We will embed the principles of the essential carer role as standard practice ***Year 3*** We will embed changes using feedback to promote better Carer experience	Complete	Complete and rolled out with positive feedback.
	Year 1 We will develop an Essential Carer role standard	Complete	Complete and rolled out with positive feedback. Key 3 themes: - Communication between essential carer and team, Understanding limitations of role and parking. All have been updated within policy.

	operating procedure and an information leaflet to support implementation. ***Year 2*** Based on the feedback and learning we will adapt the essential career role so we can achieve the best patient and essential carer experience. ***Year 3*** We will set year 3 priorities based on listening to carers.		
	Year 1 We will continue to support our carers via our carers forum. ***Year 2*** We will share learning from carers forums and use to influence improvement. ***Year 3*** We will set year 3 priorities based on listening to carers.	Complete	
	Year 1 We will consistently ensure we use carers lanyard. ***Year 2*** We will use carers stories and experiences to develop and improve services. ***Year 3*** We will monitor and record Carer feedback, involvement and inclusion in all areas of patient care	Complete	Lanyards available and accessible from General office
	Year 1 We will promote services available to carers such as Z beds.	Complete	Complete and monitored through the STAR accreditation process.

	We will continue to promote our carers charter and test this in practice using STAR. ***Year 2*** We will use our involvement services to educate staff around services available for our carers. ***Year 3*** We will improve facilities for carers to take a break form caring when in the organisation. ***Year 1*** We will ensure carers involvement in all clinical assessments and test this through STAR. We will incorporate Johns Campaign into our way of doing things. ***Year 2*** We will ensure all clinical services recognise carer involvement. ***Year 3*** We will include carer involvement in the newly designed electronic patient record and test this through STAR.	Complete	Carers role has been greater represented across the trust over the last 3 years. The Patient experience Gorup changed its name toa dd Carer in it (PCEIG) Lancashire Carer regular attend the hospital and provide feedback from patient and families. Literature around carer is also provided as team need and particular focussed at discharge. The carers forum regular supports and advises any Clinical changes to parts or development of strategies and plans.
Promote get up get dressed keep moving	***Year 1*** We will encourage patients to get up, get dressed and keep moving wherever possible to prevent	Partially Achieved	Remains constant and is monitored and being developed through the Deconditioning Big Room. A key development within falls action plan which is monitored through always safety learning and improvement group.

	deconditioning and maximise rehabilitation and experience. We will embed this in practice in 3 wards across the organisation. ***Year 2*** We will share the learning from the pilot sites to role out across all inpatient wards. ***Year 3*** We will embed these principles as our standard.		
Promote occupational and purposeful activities for our inpatients	***Year 1*** We will encourage our inpatients to engage in occupational and purposeful activities and when indicated provide suitable resources e.g. activity packs with items such as colouring, paint sets, knitting, cross stitch, cross words, puzzles, poetry, creating writing etc. We will ensure the intranet has accessible resources for staff to download for our patients. We will roll out the newly developed Reminiscence Boxes for use with our patients living with dementia. **Year 2** We will review resources and gather feedback from patients and staff. ***Year 3***	Complete	Evidence in specific areas e.g. elderly care and Finney house over the last 3 years. Stroke rehabilitation routinely carry out group activities

	We will review resources and gather feedback from patients and staff.		

Appendix 2 – Complaints Data

2.1 Comparator data for Complaints 2022 to 2025

Year	Complaints received	Increase/reduction
2022-23	487	-93
2023-24	355	-132
2024-25	325	-30

Source: LTHTR Datix

2.2 Number of Complaints by Division – April 2024 to March 2025

Division	Number (%)	Division	Number (%)
Medicine	152 (47%)	Women and Children's Services	47 (14%)
Surgery	105 (32%)	Diagnostics and Clinical Support	19 (6%)
Estates and Facilities	1 (0.5%)	Corporate Services	1 (0.5%)

Source: LTHTR Datix

2.3 Trend of ratio of complaints per patient contact 2021 to 2025

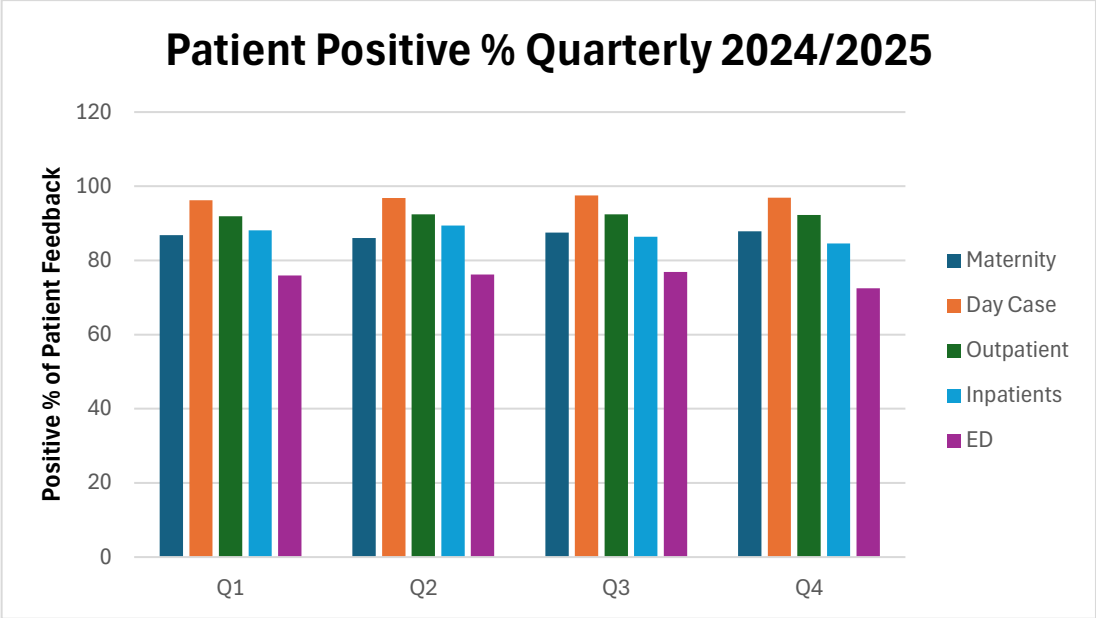
Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2021-22	580	821,526	1:1,416
2022-23	487	849,328	1:1,744
2023-24	355	882,589	1:2,486
2024-25	325	917,962	1:2,825

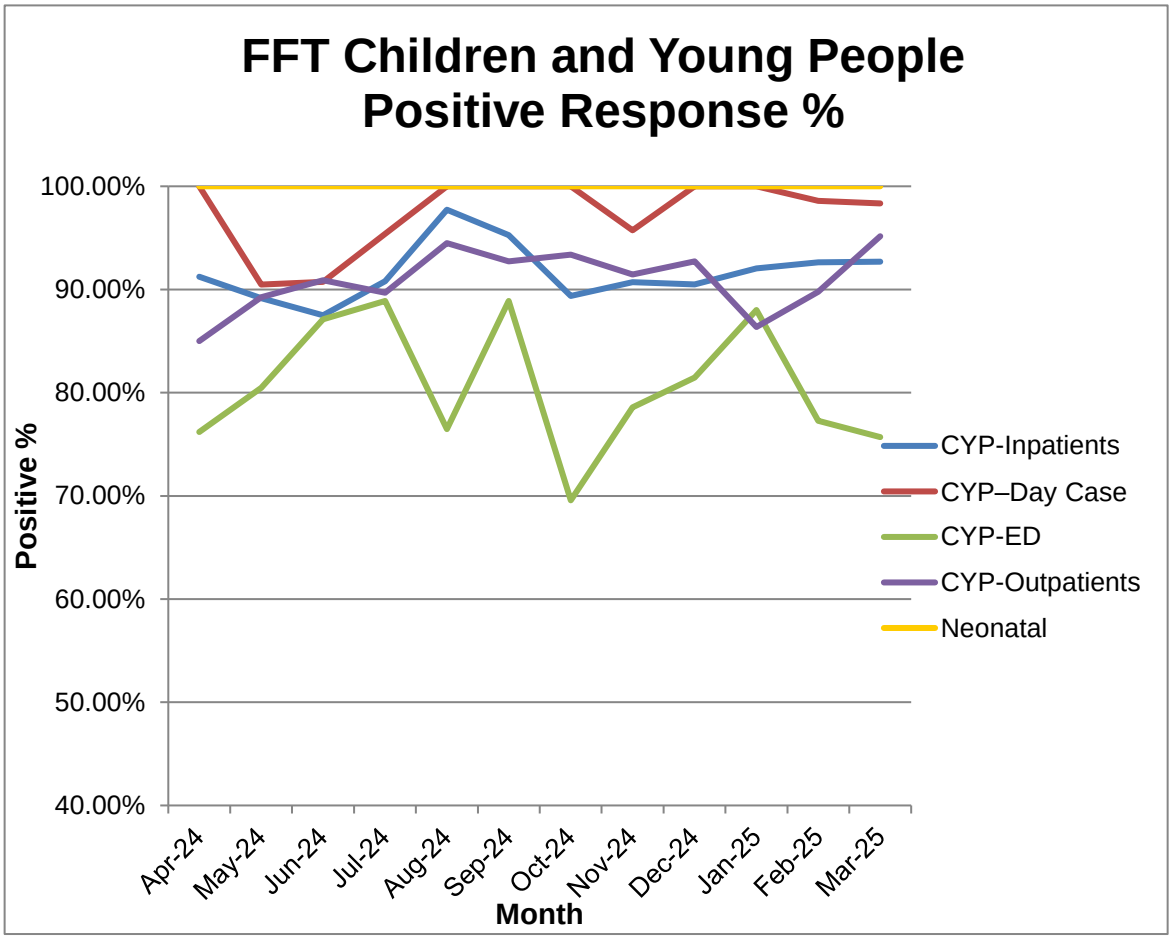
Source: LTHTR Datix

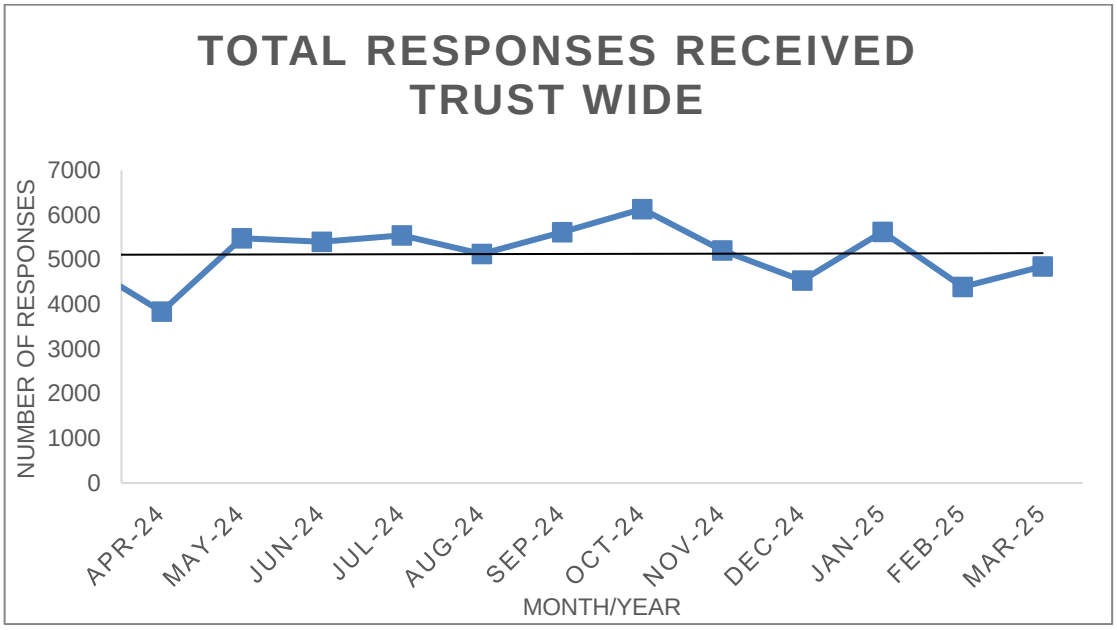
2.4 Top 3 themes from complaints by division:

Division	Themes
Diagnostic and Clinical Support	1. Communication 2. Treatment/procedure 3. Nursing care
Women and Children	1. Communication 2. Treatment/procedure 3. Nursing care
Medicine	1. Communication 2. Treatment/procedure 3. Nursing care
Surgery	1. Treatment/procedure 2. Communication 3. Staff behaviour or attitude

Appendix 3 – Friends and Family Data



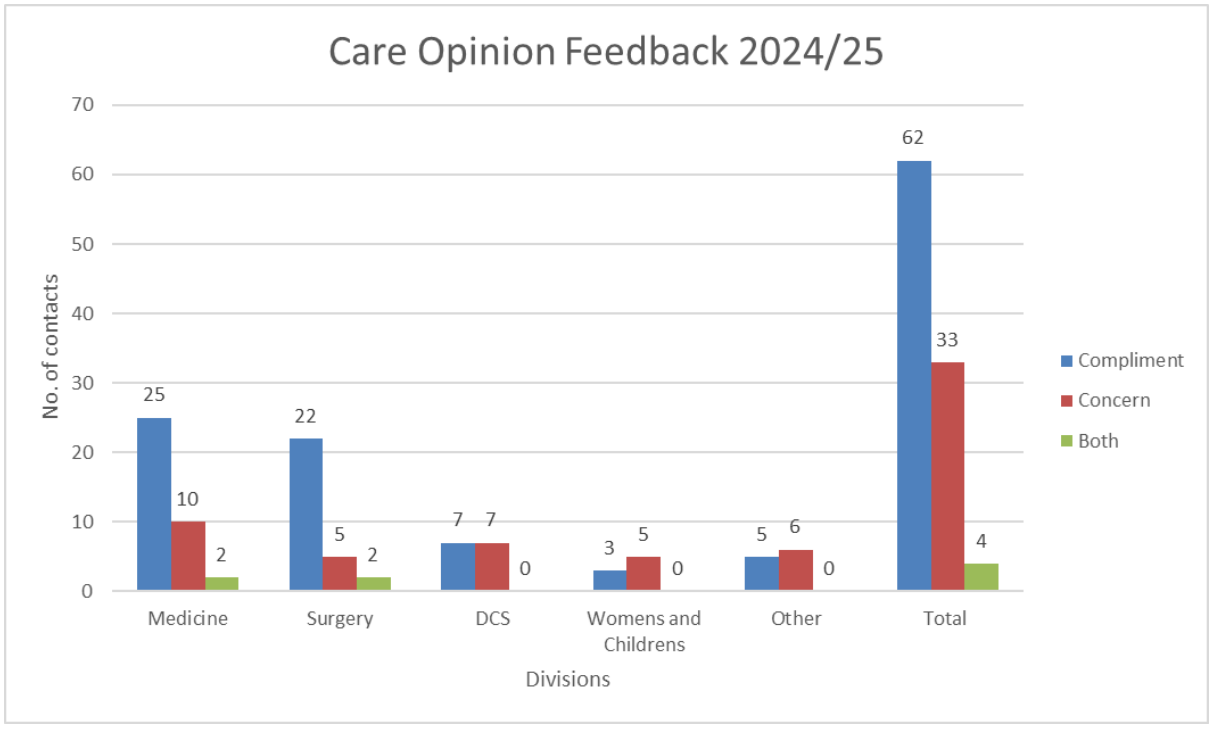




Source: FFT data CIVICA

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2022-2023	2,905	6,788	4,421	37,070	51,184
2023-2024	3,016	10,944	2,112	46,471	62,543
2024-2025	973	13,661	910	49,936	65,480

Care Opinion feedback



9.4 - PSIRF ANNUAL REPORT

REFERENCES

Only PDFs are attached

09.4 - PSIRF Annual Report 2024-2025 - Ancillary Pack.pdf

1. Introduction

1.1 The purpose of this paper is to provide an update on the implementation of the Patient Safety Incident Response Framework (PSIRF) and to provide an annual overview of incidents reported to the Strategic Executive Information System (StEIS) between 1st April 2024 – 31st March 2025 inclusive.

1.2 The paper also informs the Board of Directors of any:

- Themes and trends for incidents reported to StEIS in the reporting period 2024/25.
- Common system and process contributory factors, frequency and types of incidents causing harm and any changes in reporting patterns.
- Any patient pathways or clinical areas / specialities of concern.
- Information on common actions, relevant work streams and safety improvement projects.
- Cumulative data to provide an accurate picture of emerging trends, issues or concerns.

2. Discussion

2.1 Implementation of PSIRF

2.1.1 Throughout 2024/25, the Trust has successfully transitioned from the Serious Incident Framework (SIF) to PSIRF, embedding a comprehensive policy and implementation plan supported by a strengthened governance structure. This includes a two-tier incident triage system, with a weekly triage meeting and a weekly executive-led oversight meeting with learning triangulated in the monthly Always Safety First Learning and Improvement Group meeting. These structures ensure timely review, escalation, and learning from patient safety events.

2.1.2 The Trust's PSIRF Policy and Plan were reviewed and updated in November 2024. The updates included reflection of the PSIRF meeting structure and the Learning Response Timeframes were reviewed and updated in line with actual activity.

2.1.3 The Trust was subject to a review of its PSIRF processes by Mersey Internal Audit Agency (MIAA) in 2024/25 and is currently awaiting the final report. The report is expected to be positive and will provide external assurance on the robustness of PSIRF implementation.

2.2 Incident Reporting and Analysis

2.2.1 Incident Reporting Overview 2024/25

2.2.1.1 Incident reporting across all levels of harm in 2024/25 has remained broadly aligned with overall Trust activity, reflecting a stable and engaged reporting culture. Staff continue to demonstrate a strong commitment to identifying and escalating patient safety concerns across a wide range of clinical and operational areas.

2.2.1.2 There has been a significant reduction in the number of incidents reported to StEIS during Q1–Q4 of 2024/25. This trend aligns with the implementation of PSIRF which has shifted the approach to incident reporting. As a result, reporting levels now sit within the lower control limits, reflecting a more focused and proportionate response to patient safety events.

2.2.1.3 Incidents across all harm levels continue to be reviewed to identify high-level categories and emerging themes. Any organisational themes and trends and any areas of concern are triangulated through the relevant PSIRF governance meeting with appropriate actions put in place. In addition, learning bulletins are regularly issued in response to incidents, supporting timely dissemination of key lessons and reinforcing the Trust's commitment to continuous improvement.

2.2.2 Incident Reporting to StEIS 2024/25

2.2.2.1 Since the implementation of the PSIRF there has been a notable shift in the volume and nature of incidents reported to the StEIS. In 2024/25, a total of 19 incidents were reported to StEIS, compared to 89 in 2023/24. This reduction reflects the shift in reporting criteria under PSIRF, which now prioritises national and local priorities over harm level alone.

2.2.2.2 National priority criteria are as below:

1. Deaths thought more likely than not due to problems in care.
2. Deaths of patients detained under the Mental Health Act (1983) or where the Mental Health Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care.
3. Incidents meeting the Never Events criteria.
4. Mental health-related homicides.
5. Child deaths.
6. Maternity and neonatal incidents meeting the Health Services Safety Investigations Body (HSSIB) or Maternity and Neonatal Safety Investigation (MNSI) criteria.
7. Deaths of a person with learning disabilities.
8. Safeguarding incidents meeting criteria.
9. Incidents in NHS screening programmes.
10. Deaths in patient's custody/prison/probation.
11. Domestic homicide.

2.2.2.3 The Trust's local priority criteria are as below:

1. Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women).
2. Delayed, missed or incorrect cancer diagnosis.
3. Prescribing or administration error or near miss of anticoagulation medication.
4. Adverse discharge due to gaps in communication or misinformation.
5. Delay in responding to a critical pathology finding.

2.2.2.4 The Learning From Patient Safety Events (LFPSE) system is set to replace StEIS as the primary platform for reporting patient safety incidents. This transition aims to enhance the accuracy and comprehensiveness of incident reporting, thereby improving patient safety outcomes. For the purposes of this report, we will continue to refer to StEIS, as incidents are still being reported through this system at present.

2.2.2.5 At present, it is difficult to determine how Lancashire Teaching Hospitals incident reporting data compares to national incident reporting. This is due to the transition from the National

Reporting and Learning System (NRLS) to the LFPSE system, a new national centralised system for the recording and analysis of patient safety events in health and care services.

2.2.2.6 ***Table 1 in Appendix 1*** shows an overall summary of the number/type of incidents reported to StEIS each month by national and local priority category throughout 2024/25.

2.2.2.7 Of the incidents reported:

- 6 were classified as deaths thought more likely than not due to problems in care. This includes all cases where a patient sadly passed away and where acts or omissions in care were a contributory factor, or where the death was unexpected and required further investigation.
- 3 were Never Events, consistent with the number reported in 2023/24. All occurred within the Surgical Division and were categorised as Wrong Site Surgery (two wrong site anaesthetic injections and one wrong side eye injection), each resulting in low harm.
- 5 were aligned with the Trust's local priorities (3 under delayed recognition of a deteriorating patient, 1 under prescribing or administration error or near miss of anticoagulation medication, 1 under Adverse Discharge due to gaps in communication or misinformation)
- 5 met the Maternity and Neonatal Safety Investigations (MNSI) criteria.

All above are subject to a Trust Patient Safety Incident Investigation unless referred to MNSI* or agreed otherwise with the ICB.

** When an incident meets the criteria for the MNSI programme, it is reviewed by an independent national team. These investigations focus on understanding what happened and how care can be improved, rather than placing blame. Once accepted by MNSI, the Trust does not carry out a separate local investigation. However, it remains responsible for meeting legal duties such as the duty of candour and taking any urgent safety actions. MNSI works closely with families and staff, and shares findings and recommendations to support learning and improve maternity and neonatal care both locally and nationally.*

2.2.2.8 Of the 5 incidents which met the MNSI criteria, 2 were in relation to maternal deaths (1x ruptured ectopic pregnancy, 1 x mother found deceased in the community).

2.2.2.9 1 of the above MNSI investigations (ectopic pregnancy) has been closed during Quarter 1 2025/26. The incident was unrelated to any care received at the Trust. The remaining MNSI investigation (community death) is ongoing at the time of reporting.

2.2.2.10 Below is a breakdown of the 3 Never Events reported in 2023/24.

StEIS Ref	Datix ID	Incident Date	Division	Category	Level of Harm	Status
2024/4465	158281	25/04/2024	Surgery	Wrong site surgery – wrong side anaesthetic block	Low Harm	Investigation completed – action plan ongoing
2024/5035	161249	20/05/2024	Surgery	Wrong site surgery – wrong eye intravitreal injection	Low Harm	Investigation completed – action plan ongoing

2024/7201	169810	13/08/2024	Surgery	Wrong site surgery – wrong side anaesthetic block	Low Harm	Incident closed with complete action plan.

2.2.3 Divisional Reporting Trends to StEIS 2024/25

2.2.3.1 ***Chart 2 in Appendix 1*** shows a breakdown of incidents reported to StEIS by Division in 2024/25.

2.2.3.2 Divisional reporting to StEIS has decreased across all areas compared to the previous year.

- Surgery: 6 incidents (down from 24)
- Medicine: 7 incidents (down from 36)
- Women and Children (WACS): 6 incidents (down from 15). WACS reporting figures are in part attributable to the requirement to StEIS report all incidents which meet Maternity and Newborn Safety Investigations (MNSI) (previously HSSIB) criteria in terms of unexpected outcome and does not necessarily indicate poor care.
- Other divisions reported no incidents in 2024/25. (For Diagnostics and Clinical Support down from 8, for Corporate down from 5 and for Estates and Facilities down from 1).

2.2.3.3 This reduction also reflects the shift in reporting criteria under PSIRF, which now prioritises national and local priorities over harm level alone.

2.2.3.4 All cases reported to StEIS during 2024/25 have been included in the quarterly updates presented to the Safety and Quality Committee. These cases have been thoroughly reviewed and scrutinised at committee level, and as such, are not repeated within this report.

2.2.4 Concurrent Legal Claims, Complaints and Inquest Proceedings 2024/25

2.2.4.1 During the reporting period, 4 incidents reported to StEIS were also subject to legal claims, 2 were linked to formal complaints, and 5 incidents with an outcome of death are currently subject to inquest proceedings.

2.2.5 Notable Incidents in Early 2025/26

2.2.5.1 Although this report focuses on 2024/25, it is important to note that the Trust has reported two additional Never Events in 2025/26 to date.

StEIS ref	Datix ID	Incident Date	StEIS Reported Date	Division	Location of Incident	Category	Level of Harm
2025/1921	192854	20th March 2025	1st April 2025	Surgery	Theatre 11 - CDGH	Wrong site surgery (Cataract procedure)	No Harm
2025/2688	189825	30th January 2025	9th May 2025	Surgery	Theatre 5 - CDGH	Wrong site surgery (Part of ear - Plastics)	Low

2.2.5.2 Both incidents occurred within the Surgical Division and were categorised as Wrong Site Surgery. One of these incidents (StEIS ref 2025/2688) did not fully align with PSIRF principles. However, following consultation with the Integrated Care Board (ICB), it was confirmed as a Never Event. This highlights the ongoing challenge of applying the current Never Events Framework, which does not yet fully align with PSIRF particularly in how incidents are defined and assessed.

2.2.5.3 NHS England has advised that the findings from the recent public consultation on the Never Events Framework have been reviewed and are currently awaiting approval. Once published, the updated guidance and next steps will be shared with the PSIRF Oversight Panel.

2.2.5.4 In addition, the Trust has reported one maternal death in 2025/26. Preliminary findings have concluded the death was associated with natural causes attributed to a pregnancy complication. Nevertheless, the case has been referred to MNSI in line with criteria.

2.2.6 Regulation 28 – Prevention of Future Deaths Received 2024/25

2.2.6.1 During the 2024/25 reporting period, the Trust received one Regulation 28: Report to Prevent Future Deaths from the Coroner.

2.2.6.2 The concerns raised related to the management of patients with complex needs who remain in the Emergency Department (ED) for extended periods. The Coroner concluded that the patient's death was preventable, citing a verdict of neglect due to failures in:

- Providing timely and appropriate assessment and medical care
- Escalating the management of the patient's asthma to specialist teams

2.2.6.3 In response, the Medicine Division developed a comprehensive action plan, which was submitted to the Coroner in November 2024. This plan has been subject to regular review and oversight by the PSIRF Oversight Panel, ensuring that:

- Agreed actions are being embedded into practice
- Outstanding actions remain on track for delivery

2.2.6.4 The Trust remains committed to learning from this case and ensuring that the necessary improvements are made to prevent similar incidents in the future.

2.2.7 Closed Cases 2024/25

2.2.7.1 Closed StEIS cases in 2024/25 (both under SIF and PSIRF)

2.2.7.1.1 Summaries of closed StEIS cases from earlier quarters have been reported and scrutinised through quarterly updates to the Safety and Quality Committee and therefore not duplicated in this report.

2.2.7.2 Legacy SIF Cases and Closure Activity

2.2.7.2.1 As of 29 April 2025, there are no open Level 3 SIF investigations.

2.2.7.2.2 A number of Level 1 and 2 non-StEIS SIF cases remain open and are being actively monitored by the PSIRF Oversight Panel, with a continued downward trajectory.

2.3 Transition from SIF to PSIRF: Activity Trends and Key Performance Indicators

2.3.1 Comparative Activity Analysis: SIF vs PSIRF

2.3.1.1 The implementation of the PSIRF in November 2023 marked a significant shift from the previous SIF. PSIRF introduces a broader and more flexible range of learning responses, allowing the Trust to tailor its approach based on the nature and complexity of each incident. These include:

- **PSIRF SWARM Huddle:** A rapid-response, team-based huddle conducted immediately after an incident. Staff 'swarm' to the site to quickly understand what happened, why it happened, and what actions are needed to reduce risk.
- **After Action Review (AAR):** A structured evaluation method used when an outcome has been particularly successful or unsuccessful. It aims to capture learning to avoid future failures and promote success.
- **Patient Safety Incident Investigation (PSII):** In depth investigation into a case.
- **Multi-Disciplinary Team (MDT) Review:** A collaborative review involving multiple disciplines to explore safety themes, pathways, or processes. It helps identify contributory factors and system gaps across multiple incidents.
- **Thematic Review:** A qualitative approach to identifying patterns and themes across incidents. This method is used to explore recurring issues and inform broader system-level improvements.

2.3.1.2 Since July 2024, the monitoring of learning responses has been conducted, including timeliness of learning response completion. This data is presented to the PSIRF Oversight Panel monthly via the Learning Response SitRep, which covers compliance with deadlines and the duration of investigations.

2.3.1.3 Whereas SIF focused on identifying and investigating serious incidents with a focus on compliance and accountability, which was often reactive and incident driven, PSIRF focuses on learning and improvement, encouraging proactive, systems based and learning orientated approaches which promote a supportive and just culture. Analysis of activity pre and post PSIRF implementation allows the Trust to examine whether PSIRF is leading to more meaningful investigations, whether the types of investigations have changed and whether proportional responses are being undertaken with the aim to undertake fewer investigations with greater impact, which aligns with organisational priorities and is an effective use of resources.

2.3.1.4 A review of activity across the two frameworks comparing activity under the SIF in 2023 and PSIRF in 2024 has highlighted several key trends:

• Fewer PSIIs have been commissioned under PSIRF than Serious Incident Investigations under SIF, reflecting a shift toward proportional, learning-focused responses in line with PSIRF as expected. • AARs remain the most frequently used learning response, particularly for incidents aligned with National and Local Priorities. • Thematic Reviews have increased under PSIRF, replacing the more rigid cluster investigations used under SIF. • Locally managed incidents varied across the period

2.3.1.5 However, feedback from Divisions has highlighted challenges, particularly around the volume of AARs, which can impact the ability to meet key performance indicators. Additionally, learning responses such as SWARMs and MDT Reviews remain underutilised. In response, the Trust is actively promoting the use of SWARMs as a faster, team-led method that empowers frontline staff and reduces reliance on governance teams.

2.3.1.6 Between January and December 2024, the Trust identified 279 incidents aligned with National Priorities and 1,082 with Local Priorities. However, the number of PSIIs commissioned did not meet the expected target of five per local priority, as outlined in the Patient Safety Incident Response Plan (PSIRP). Many incidents were managed locally or addressed through alternative learning responses most commonly AARs when initial assessments indicated that a full investigation would not generate new learning. This approach reflects PSIRF's emphasis on proportionality and effective use of resources.

2.3.1.7 To support continuous improvement, the Corporate Governance team hosted a Governance Forum in May 2025, bringing together Divisional Governance teams to review learning response activity and explore strategies for selecting the most appropriate response. This forum also focused on maximising the value of investigations while ensuring efficient use of resources.

2.3.1.8 In 2025/26, the Trust will undertake a comprehensive review of its PSIRF Local Priorities to ensure they remain aligned with the organisation's overarching safety profile. This process will help to confirm if current priorities are both relevant and effective in supporting a safe, high-quality environment for all stakeholders. The review will also provide an opportunity to make any necessary adjustments in response to emerging risks, regulatory changes, or evolving community needs.

2.3.1.9 This approach supports the Trust's broader aim of embedding a responsive, proportionate, and sustainable learning culture across all services.

2.3.2 Key Performance Indicators (KPIs)

2.3.2.1 To support effective monitoring of timeliness and delivery, the Trust introduced Key Performance Indicators (KPIs) in February 2025:

PSIIs:	• Red: >182 days since commissioning • Amber: 153–182 days • Green: ≤153 days
AARs:	• Red: >30 days since commissioning

	• Green: ≤30 days

2.3.2.2 These KPIs have been shared with the Safety and Quality Committee to support oversight and assurance.

2.3.2.3 To enhance visibility and support real-time monitoring, these KPIs are being integrated into the BI Portal Governance Dashboards. This will support timely reporting and oversight at Divisional Improvement Forums and ensure consistent inclusion in the quarterly PSIRF reports submitted to the Safety and Quality Committee.

3. Learning from Practice and Insight: Embedding Organisational Learning and Improvement

3.1 Building a Learning Culture

3.1.1 The Trust continues to strengthen its commitment to becoming a learning organisation by embedding structured approaches to learning, reflection, and improvement across all levels of care. This work is underpinned by the principles of the PSIRF and is driven by a culture that values openness, curiosity, and continuous improvement.

3.1.2 Key enablers include

- **Always Safety First Strategy Refresh:** To support a more strategic and coordinated approach to learning, the Always Safety First Learning and Improvement Group has begun shaping a refreshed Trust-wide Safety and Learning Strategy, scheduled for launch in 2025/26. This strategy will place learning at the heart of the Trust's safety agenda and will guide how learning is captured, shared, and translated into improvement.
- **Organisational Wide Learning Bulletins:** A dedicated Learning Task and Finish Group has been established to support this work. A key output has been the relaunch of Safety Learning Bulletins, which are now issued regularly to share learning across the organisation. These bulletins cover both specific themes and broader safety insights and are distributed through multiple platforms to ensure accessibility. A bi-monthly roundup bulletin also provides a consolidated view of recent learning and developments.

3.2 Learning Through Engagement and Insight

3.2.1 The Trust fosters learning through direct engagement with staff and patients, ensuring that insights from practice inform improvement.

- **Community of Practice Events:** Throughout 2024/25, the Trust has hosted a series of Community of Practice events, drawing on insights from the weekly triage and PSOP meetings and incident reviews. These sessions have focused on key themes such as:
  - Infection prevention and control
  - Listening to patients
  - Leadership and safety culture
  - Care for individuals with learning disabilities and autism

- **Leadership Safety Visits:** Monthly leadership safety visits, providing real-time insights from clinical areas. These visits have focused on practical safety challenges, including:
  - Escalation of care for deteriorating patients
  - Managing safety in areas with boarded beds
  - Pressure ulcer prevention and use of the Purpose T tool

- Reasonable adjustments for patients with dementia, learning disabilities, and autism
- VTE risk assessments and fluid balance management
- Compliance with World Health Organisation (WHO) theatre safety checks

3.2.2 These activities support a continuous feedback loop between frontline teams and leadership, helping to identify risks early and share good practice.

3.3 System Learning and Targeted Improvement

3.3.1 Aligned with PSIRF, the Trust is also evolving its approach to improvement planning. Where recurring safety issues are well understood, the focus has shifted from repeated investigations to the development of targeted improvement plans that address underlying system issues.

3.3.2 This work is overseen by the Always Safety First Learning and Improvement Group and follows a phased, system-based approach:

- Safety I: Reviewing past incidents to identify opportunities for improvement
- Safety II: Learning from areas of good practice internally and externally
- Local Knowledge: Engaging frontline staff to understand current practice and challenges
- Patient Involvement: Involving patient safety partners and individuals affected by incidents

3.3.3 This approach ensures that improvement efforts are evidence-based, inclusive, and aligned with both local context and national priorities.

3.4 Trust-Wide Learning Themes and Improvement Actions

3.4.1 To strengthen organisational learning and drive continuous improvement, Divisions regularly present incident themes, trends, and learning at the PSIRF Level 2 Triage Meetings and the Always Safety First Learning and Improvement Group. These forums provide a structured opportunity to share insights, identify cross-cutting issues, and coordinate improvement actions across the Trust.

3.5 This collaborative approach ensures that learning is not siloed but is used to inform system-wide safety improvements and support a culture of openness and shared accountability.

3.5.1 Examples of common and emerging themes, along with associated improvement actions, are detailed below.

Thrombectomy Service	The Trust provides a mechanical thrombectomy service for the population of Lancashire and South Cumbria. Thrombectomy is a highly specialised, time-critical treatment for certain types of stroke. While the national service specification sets out an ambition for 24/7 availability, very few centres across England currently operate a full 24-hour thrombectomy service, due to significant national workforce shortages. Since its commissioning in October 2021, the Trust has adopted a phased approach to expanding the service, in agreement with Specialist Commissioners. Service hours have evolved over time in response to staffing availability, with periods of reduced weekend coverage. Full weekend coverage resumed in January 2025 following

	successful recruitment of additional Interventional Neuroradiologists (INRs). Despite these efforts, some patients have experienced delays in accessing thrombectomy, particularly during weekends or outside of commissioned hours. A thematic review commissioned under PSIRF in December 2024 examined 17 such incidents. In six cases, staffing gaps were identified as a possible contributory factor. The review also highlighted inconsistencies in how thrombectomy-related incidents are reported across different centres. The Trust's detailed reporting approach has prompted national discussions, and NHS England is now reviewing how thrombectomy incidents are reported to ensure consistency and transparency. The Trust remains committed to improving access to thrombectomy and continues to work closely with regional and national partners to strengthen service resilience and patient outcomes.
Venous Thromboembolism (VTE) Management	Ongoing incidents related to anticoagulant prescribing and administration have led to the formation of a VTE Group and the development of a Trust-wide VTE Improvement Plan. This work focuses on improving assessment, prescribing, and documentation practices. VTE remains a PSIRF Local Priority, with most incidents resulting in low or no harm. Insight from a May 2025 leadership safety visit is further informing the work of this group.
Missed Cancer Diagnoses and Follow-Up	A new risk was added to the Trust Risk Register in April 2024. A Missed Cancer Improvement Plan, supported by RAD-Alert, is addressing delays and manual tracking issues, with further work ongoing to strengthen diagnostic tracking.
Endoscopy Waiting Lists	Capacity constraints and outdated referrals have led to risks in endoscopy services. A rapid improvement week in January 2025 identified scheduling efficiencies, and a digital validation tool (PEP Plus) is now used to manage waiting lists more effectively. Safeguards are in place to ensure high-risk patients are not removed without clinical review.
Governance of Invasive Procedures (LocSSIPs)	A review of the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs) identified gaps in oversight, documentation, and consistency. A Trust-wide improvement programme is underway which includes a review of the policy and development of a standardise LocSSIP library.,

3.5.2 Other learning has also been identified at a Divisional level through locally managed incidents. Cases have related to the management of the Stroke Pathway for Children, Fluid Balance Management, identification of Propofol Related Infusion Syndrome (PRIS) and incorrect/over exposure of patients to ionising radiation during Radiotherapy treatment. In all cases, Learning Responses were completed locally where it was identified that further investigation was unlikely to yield further learning.

3.5.3 These themes reflect the Trust's proactive approach to identifying risks, learning from incidents, and implementing system-level improvements. Progress is monitored through governance forums, with learning shared across Divisions.

3.6 Managing High-Frequency Incidents Through Targeted Improvement

3.6.1 While not aligned to PSIRF National or Trust Local Priorities due to limited new learning and existing improvement programmes, Falls, Pressure Ulcers, and Clostridioides difficile (C. difficile) remain among the most frequently reported incidents across the Trust. These areas continue to receive focused attention through dedicated improvement plans and oversight mechanisms.

Clostridioides difficile (C. difficile):	In response to a rise in C. difficile cases, the Trust has implemented a comprehensive C. difficile Improvement Plan, overseen by the Chief Nursing Officer and supported by Divisional, Estates and Facilities, and Health and Safety teams. Key actions include: • Environmental improvements, including waste management and discouraging non-biodegradable wipes • Enhanced cleaning standards to meet national protocols • Strengthened Infection Control policy with improved assurance mechanisms • Learning from MDT reviews and Datix screening tools shared via the Infection Control dashboard • Participation in national hand hygiene research (commenced October 2024). During 2024/24, the trust reported 192 hospital-associated cases, successfully meeting the national objective of 199 cases, and achieving this target for the first time since 2018. This represents a 5% reduction from the previous year's total of 203 cases, despite the national threshold increasing from 121 to 199. However, the The Trust continues to rank high among major Trusts in terms of C. difficile cases per 100,000 bed days
Pressure Ulcers	The Pressure Ulcer Improvement Plan has focused on: • Risk assessment and care planning aligned with national guidance • Targeted work on medical device-related ulcers, especially catheter-related • Updated training via a new e-learning package • Patient empowerment initiatives co-designed with Patient Safety Partners • A new review tool integrated into Datix and a dashboard (launched March 2025) for thematic analysis and oversight. During 2024/25, the trust has seen a: • 16% reduction in total Category 2+ pressure ulcers. • Significant reduction in severe harm incidents (from 17 to 2), indicating improved early intervention and care. • Reduction in medical device-related ulcers, reflecting the impact of focused prevention strategies.

	• Slight increases in low and moderate harm incidents, which may reflect improved reporting or areas requiring further attention.
Falls	Falls prevention remains a key improvement priority. Recent developments include: • A new Falls training package with enhanced care levels. • Merging of Falls Prevention and Deconditioning Big Rooms to improve risk assessment compliance. • Use of the Continuous Improvement Big Room model to test and embed improvements. • A target of 5% year-on-year reduction in falls, with inclusion in the Single Improvement Plan from 2025 due to unmet targets. During 2024/25, the trust has seen a: • 4.23% increase in total inpatient falls. However, this must be viewed in the context of increased patient numbers and hospital occupancy. • Reduction in high ham incidents (severe harm or death) decreased from 17 to 12. This suggests improved fall prevention strategies or better risk mitigation for vulnerable patients. • Since raw fall numbers can be misleading due to fluctuating patient volumes, the Trust uses falls per 1,000 bed days as a more accurate performance metric and this is showing a stable performance over time.

3.7 Additional Themes (Analysis of Health Inequalities and Protected Characteristics and Communication and Staffing questions)

3.7.1 Within PSII Templates, the Trusts explores four additional questions as a standard to begin to understand if there are some common underlying factors that may contribute to safety. These questions are:

- Did the people impacted by the patient safety event have any associated health inequalities?" and "Did health inequalities contribute to the cause of the patient safety event and to what extent?
- Has the subjects of the patient safety event been unfairly impacted as a result of a protected characteristic?
- Was there evidence of poor / inappropriate communications between staff / services and patients, families and carers?
- Were there adequate staffing levels at the time of the patient safety event?

3.7.2 In April 2025, an analysis of these questions were undertaken. These are summarised below.

- Investigations generally did not find direct evidence of health inequalities contributing to patient safety events but acknowledged potential indirect impacts.
- Protected characteristics such as age, sex, race, and disability status were consistently identified, but no direct evidence of unfair impact was found, except in one case related to dementia.
- Inconsistent communication was consistently linked to adverse patient safety events, highlighting the need for improved protocols.
- Staffing levels were identified as a recurring patient safety priority, with variations impacting patient outcomes.

Whilst the analysis gave a large degree of helpful insight, further data is required to make further inferences. The data is scheduled to be discussed at the next Always Safety First Learning and Improvement Group meeting and updates on improvement actions will be provided in future reports to the Safety and Quality Committee.

4. Patient Involvement and Support

4.1 The Trust remains committed to placing patients, families, and carers at the centre of its safety and learning processes. This includes upholding the principles of openness, transparency, and meaningful involvement throughout the patient safety journey.

4.2 Duty of Candour (DoC)

4.2.1 DoC has been applied to all incidents reported to StEIS, except in cases where a justifiable exclusion has been identified such as when a patient or family declines communication, or when contact details cannot be obtained despite best efforts. Compliance with DoC is monitored weekly through the PSIRF Oversight Panel, with Divisions encouraged to escalate any anticipated exceptions or requests for support. Compliance with DoC is also monitored in the monthly Safety and Quality Dashboard at the Safety and Quality Committee.

4.2.2 The Trust is committed to strengthening its adherence to all aspects of the Duty of Candour, with a particular focus on improving compliance with both Part 1 (initial notification) and Part 2 (sharing findings) requirements. This includes ensuring that patients and their families are promptly informed when incidents occur that result in harm, and that they receive a full, open, and honest explanation, along with a sincere apology.

4.2.3 To strengthen compliance, the Corporate Governance team has enhanced the daily and weekly DoC situation reports and delivered targeted educational sessions, resulting in measurable improvements. Additionally, the Trust launched a new **Being Open Policy**, which replaces the previous DoC policy. This updated policy aligns with PSIRF and outlines the Trust's approach to open communication, including in cases that do not meet the threshold for a notifiable safety incident. It also introduces the role of the **Engagement Lead**, who supports communication with patients and families during investigations.

4.3 Patient Safety Partners (PSPs)

4.3.1 The Trust has embraced the national Patient Safety Partner (PSP) model, appointing three PSPs in November 2023. These individuals', patients, carers, or members of the public play a vital role in shaping the Trust's safety agenda. PSPs are core members of the Always Safety First Learning and Improvement Group, the PSIRF Oversight Panel, and the Patient Experience and Involvement Group, rotating every three months.

4.3.2 Beyond committee involvement, PSPs contribute to key safety initiatives, including:

- Pressure ulcer, falls, and medication safety improvement projects
- Recruitment panels for patient safety roles
- Departmental walk rounds following Never Events
- Development of patient information resources

4.3.3 Their contributions help ensure that patient perspectives are embedded in decision-making, risk identification, and improvement planning. PSPs have been instrumental in promoting openness,

highlighting what matters most to patients, and helping the Trust understand how care processes are experienced by those who use them.

4.4 Support for Patients, Families, and Carers

4.5 To further support those affected by patient safety incidents, the Trust has developed a PSIRF Patient Information Leaflet. This resource outlines what patients and families can expect during an investigation and provides guidance on where to seek additional support.

4.6 The Being Open Policy also plays a key role in ensuring that patients and families are informed, involved, and supported throughout the investigation process. It reinforces the Trust's commitment to respectful communication, transparency, and continuous learning.

4.7 Feedback from bereaved families attending inquests has provided valuable insights into both the care received and their experience of the process. This feedback is shared with Divisions for reflection at Safety and Quality meetings and is formally reported through the Trust's Mortality and Learning from Deaths reports.

5. Staff Training and Support

5.1 Training Compliance

5.1.1 As of 29th April 2025, the Trust has demonstrated strong compliance with the national Patient Safety Training Framework, reflecting a well-embedded culture of safety and learning across the workforce:

Topic	Compliance (Within Target Audience)
Level 1 – Essentials of Patient Safety for all staff	94%
Level 1 – Essentials for Patient Safety for boards and senior leadership teams	90%
Level 2 – Patient Safety Access to Practice	92%

5.1.2 In addition to core training, the Trust has supported staff in completing nationally accredited PSIRF role-specific training, ensuring those in key safety roles are equipped with the necessary skills and knowledge:

Topic	Numbers of people who have completed training
PSIRF – Oversight	41
PSIRF – Systems Approach	104
PSIRF – Engagement	250

5.1.3 Additional in-house training has also been delivered through the Nursing, Midwifery and AHP Forum and to Medical and Divisional Governance Leads throughout the year.

5.1.4 These figures reflect the Trust's commitment to building capability at all levels, from frontline staff to senior leadership.

5.2 Staff Support and Wellbeing

5.2.1 Recognising the emotional impact that patient safety incidents can have on staff, the Trust is committed to strengthening its approach to staff debrief and emotional support. The focus for 2025/26 will be on enhancing support and developing toolkits to ensure that colleagues feel heard, supported, and valued throughout the incident response journey.

5.2.2 This work forms part of the Trust's broader commitment to fostering a compassionate, inclusive, and psychologically safe working environment, where staff wellbeing is prioritised alongside patient safety. By embedding supportive practices into the response framework, the Trust aims to promote resilience, learning, and a culture of care for both patients and staff.

6. Additional Improvement Actions

6.1 Transition to the Learning From Patient Safety Events (LFPSE) System

6.1.1 The Learning From Patient Safety Events (LFPSE) system, a new national centralised system for the recording and analysis of patient safety events in health and care services is being introduced nationally to replace the Strategic Executive Information System (StEIS) as the primary platform for reporting patient safety incidents. This transition is intended to improve the accuracy, consistency, and comprehensiveness of incident reporting, ultimately supporting better patient safety outcomes across the NHS.

6.1.2 Lancashire Teaching Hospitals has already transitioned its Datix system to the LFPSE platform. This marks a significant step forward in aligning with national reporting standards and enhancing the quality of safety data available for analysis. The Trust is currently preparing to upgrade to LFPSE version 6.0, which will further strengthen analytical capabilities and ensure full compliance with evolving national requirements.

6.1.3 While the transition is underway, incidents continue to be reported through StEIS for the purposes of this report. It is important to note that, due to the ongoing national shift from the National Reporting and Learning System (NRLS) to LFPSE, it remains difficult to benchmark the Trust's incident reporting data against national figures. This limitation is expected to improve as the LFPSE system becomes fully embedded across the healthcare system.

6.1.4 In the meantime, the Trust continues to monitor internal trends closely and adapt its systems to ensure high-quality reporting. Enhancements to Datix have also included the integration of tools for C. difficile and Pressure Ulcer reviews, supporting more robust post-incident analysis and learning.

6.2 Working with system partners and ICB

6.2.1 The Trust continues to work with system partners and the ICB to share learning and also best practice. The Trust has also completed several joint investigations with partner organisations to support shared understanding and improvement.

7. Looking Ahead: Priorities for 2025/26

7.1 The success of PSIRF requires a collaborative approach that balances what is practical, effective, and manageable for our teams, while not losing sight of our core commitment to patient safety and continuous learning. The Trust is committed to working collaboratively with teams

across the organisation to embed a culture that supports meaningful improvement and sustainable change.

7.2 The focus for 2025/26 will therefore include deepening the integration PSIRF into everyday practice and enhancing learning systems, reflecting the Trust's ongoing dedication to creating a safer, more transparent, and continuously improving healthcare environment

7.3 In 2025/26, the Trust will carry out a full review of the PSIRF plan and workforce requirements, in line with the original implementation strategy. This will align with the launch of the new Always Safety First strategy in September 2025, coinciding with World Patient Safety Day.

7.4 Planned priorities include:

- Comprehensive review of the PSIRF Local Priorities to ensure they remain aligned with the organisation's overarching safety profile.
- Developing new processes in the Datix system, including a falls review tool, to support better analysis of themes and trends.
- Creating a tailored in-house training programme to build PSIRF capability and sustainability.
- Ensuring consistent and meaningful reporting against local safety priorities to the Safety and Quality Committee.
- Integrating key performance indicators into governance dashboards to monitor the timeliness of learning responses.
- Improving how learning responses are tracked and monitored.
- Exploring enhancements in Datix to help governance teams identify patterns and generate useful insights.
- Strengthening systems for tracking safety actions.
- Launching post-incident engagement surveys to gather feedback from patients and families involved in investigations.
- Placing greater emphasis on measuring and demonstrating the impact of safety improvements on patient outcomes.
- Increasing the use of thematic and multidisciplinary reviews.
- Including health inequalities in patient safety reporting and analysis.
- Supporting patients and staff who have experience safety events.

8. Financial implications

8.1 None

9. Legal implications

9.1 The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute healthcare providers.

9.2 There are some incidents that are subject to claims and the Trust has received a Regulation 28 regarding 1 incident.

9.3 Lack of timely DoC may lead to CQC enforcement action.

10. Risks

10.1 The Trust continues to manage a number of active risks related to patient safety, service delivery, and compliance. All risks are monitored through the Trust's governance structures, with progress and mitigation actions reviewed regularly. One high-risk issue related to radiology reporting has been successfully mitigated and closed.

Risk ID	Active Risk Title	Score
584	Risk of patient harm due to limited provision of the Neurointervention service	15
1264	Management of the Trust's Sentinel Stroke National Audit Programme (SSNAP)	9
1960	Risk of missed diagnosis in cancer	12
1969	Duty of Candour not consistently applied within Trust targets	12
1970	Trust's ability to robustly embed the PSIRF Incident Management Processes	12
803	Never Events	12
2074	Oversight of LocSSIPs	12
1808	Risk of delay to patient pathways due to inability to deliver core services – Endoscopy	15
1702	Inadequate clinical resource to clinically validate the therapeutic and surveillance endoscopy waiting lists	20
Risk ID	**Closed Risk Title**	
1044	Inconsistent pathways for monitoring and actioning radiology reports resulting in delayed diagnosis / patient harm.	

11. Impact on stakeholders

11.1 There may be a negative impact on patients, families and staff who are affected by serious incidents. The findings of investigations together with the recommended corrective actions are always offered to be shared with the patient and family. Staff are also supported following the incident, during the investigation and after the investigation as concluded, should this be required.

12. Recommendations

12.1 It is recommended that the Board of Directors:

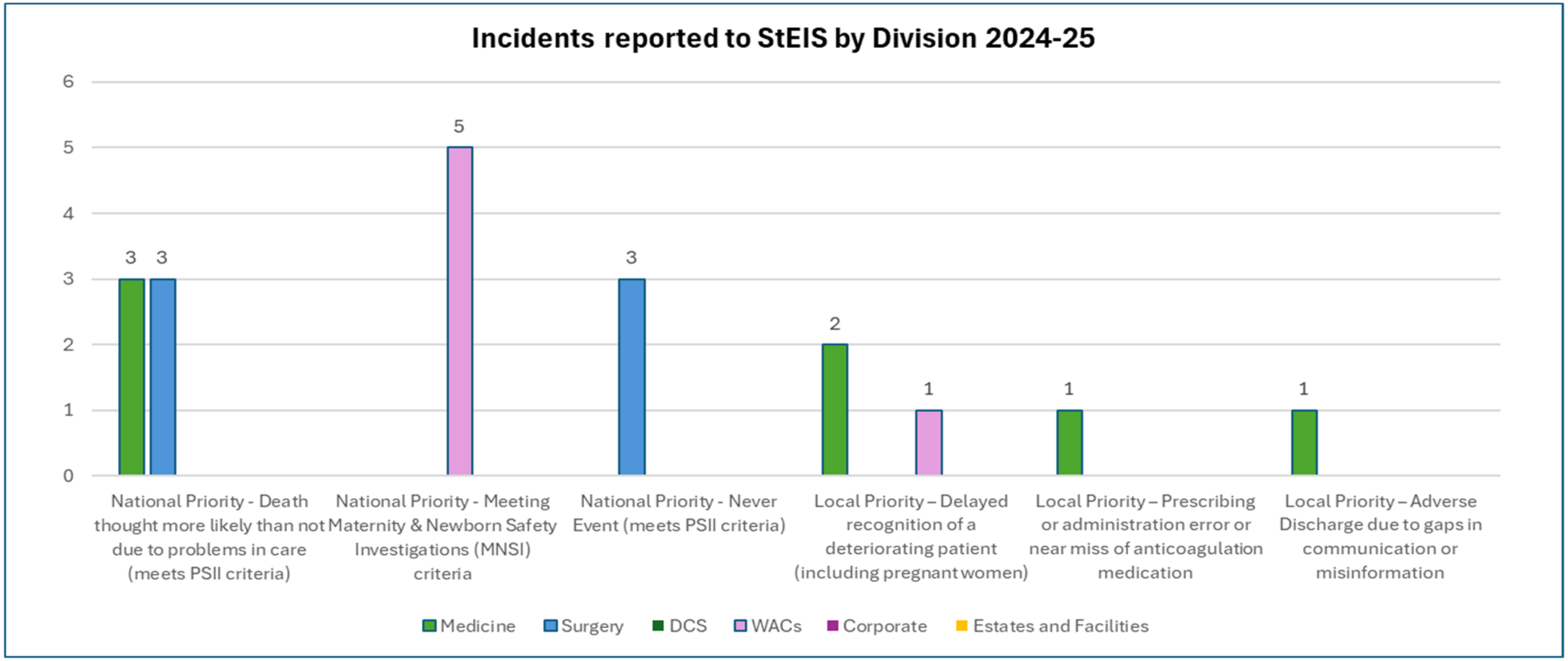
i. Receive the updates on the implementation of PSIRF and confirm they are assured on the management of incidents

Appendix 1 - Charts and Graphs

Table 1: Number/type of incidents reported to StEIS each month by category - 2024/25

		Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
National Priorities - PSIRF	National Priority - Child Deaths													**0**
	National Priority - Death thought more likely than not due to problems in care (meets PSII criteria)					2			2			2		**6**
	National Priority - Meeting Maternity & Newborn Safety Investigations (MNSI) criteria (referred to MNSI for review)						2	1		1	1			**5**
	National Priority - Never Event (meets PSII criteria)		2			1								**3**
	National Priority – Mental Health related homicides													**0**
	National Priority – Deaths of persons with learning disabilities													**0**
	National Priority – Incidents in NHS screening programmes													**0**
	National Priority – Domestic Homicide													**0**
	National Priority – Deaths of patients maintained under the Mental Health Act													**0**
	National Priority – Safeguarding incidents meeting criteria													**0**
Local Priorities - PSIRF	Local Priority – Delayed recognition of a deteriorating patient (including pregnant women)	1							1				1	**3**
	Local Priority – Delayed, missed or incorrect cancer diagnosis													**0**
	Local Priority – Prescribing or administration error or near miss of anticoagulation medication			1										**1**
	Local Priority – Adverse Discharge due to gaps in communication or misinformation				1									**1**
	Local Priority – Delay in responding to a critical pathology finding													**0**
	Overall total by month	**1**	**2**	**1**	**1**	**3**	**2**	**1**	**3**	**1**	**1**	**2**	**1**	**19**
	Overall total quarter		**4**			**6**			**5**			**4**		

Chart 2 – Breakdown of incidents reported to StEIS by Division 2024/25



10.2A - WRES

REFERENCES

Only PDFs are attached

10.2a - WRES 2025.pdf

Board of Directors

Workforce Race Equality Standard (WRES) Submission 2025			
Report to:	Workforce Committee	**Date:**	3rd June 2025
Report of:	Chief People Officer	**Prepared by:**	M. Davis

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

Executive Summary:

The purpose of this report is to share the data which will form the submission and subsequent publication of the 2025 Workforce Race Equality Standard (WRES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest staff survey. The Committee are asked to review and approve the contents of the report for publication and to consider the areas for action and associated next steps which are to consult with the Ethnicity Inclusion Forum with regards to the results, understand their lived experience, the actions which will make the greatest impact and to co-design a draft action plan, making changes where necessary. The Trust is part of the Lancashire and South Cumbria Integrated Care Board (ICB) Belonging Delivery Group and are working collaboratively on a number of projects with the aim of improving the WRES data.

The priority areas recommended for action are those which indicate ethnic minority colleagues are being adversely impacted or disadvantaged according to the four-fifths rule:
Indicator 2 – Relative likelihood of staff being appointed from short listing across all posts.
Indicator 8 – In the last 12 months, have you personally experienced discrimination at work from your manager or
colleagues.
Indicators 1 and 9 – Increased representation of ethnic minority colleagues in senior, VSM or voting Board member roles.

It is recommended that the Board of Directors

Receives and notes the report.

Approve the report for publishing report externally.

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			
Workforce Committee – 13th May 2025			

INTRODUCTION

The Workforce Race Equality Standard (WRES) is a mandated requirement through the NHS standard contract; this is the tenth report since it was established in 2016. Organisations are mandated to report and publish their WRES data on an annual basis, illustrating their progress against nine indicators relating to workforce race equality. This report allows us to understand where the data indicates the areas of greatest challenge and where we are performing well. It also enables us to benchmark our position as a Trust against nationally available findings for each of the 9 WRES Indicators.

RESULTS

For each of the indicators the data is compared for White and Ethnic Minority colleagues. National staff survey averages and Trust results for the last 6 years have been included for comparative purposes (where applicable) to the metric being reviewed. This year we have requested additional reports from Picker to help us interrogate our staff survey results further and understand how colleague experience in white and ethnic minority subgroups may vary across Division and Band. Unfortunately, this data has not been available to us in time for the writing of this report however we will utilise the information to help us develop more targeted actions moving forwards.

Completion rates

	Total Org Response	White colleagues	Ethnic Minority colleagues	Unknown
2024	3996	3138	821	0
2023	4539	3503	986	50
2022	4440	3538	862	40
2021	4311	3413	626	272

The table above shows the numbers of colleagues completing the staff survey each year. In 2024 the total number of colleagues who completed the staff survey dropped by 12% overall; this was reflected more significantly in the reduction of ethnic minority colleagues who had completed (16.5% less). What we don't yet understand is what percentage of colleagues who are invited to complete the staff survey each year, use the opportunity to share their views and experiences. This is something we are hoping to be able to understand working with the OD Projects team moving forwards.

Summary Data

The approach used by the national WRES team is to utilise what is referred to as the four-fifths (or "80 percent") rule to highlight whether practices may be having an adverse impact on an identified group e.g. a sub-group of ethnicity. If the relative likelihood of an outcome for one sub-group compared to another is **less than 0.8 or higher than 1.25**, then the process would be identified as potentially having an adverse impact on one of those sub-groups. This will be referred to as the Disparity Ratio throughout the report.

Improvements have been seen for Ethnic Minority colleagues across the following WRES indicators;

- **Indicator 5 – Percentage of colleagues experiencing bullying, harassment or abuse from the public.** The staff survey result has worsened for white colleagues (21.7% to 22.6%) and has improved for ethnic minority colleagues (22.51% to 20.70%) over the last 12 months. The disparity ratio is now 0.92 which indicates ethnic minority colleagues report a slightly better experience in this area than white colleagues.
- **Indicator 6 – Percentage of colleagues experiencing bullying, harassment or abuse from colleagues.** This score has again improved for ethnic minority colleagues over the last twelve months (23.40% to 21.30%) whilst deteriorating for white colleagues (20.40% to 21.10%). The disparity ratio now stands at 1.01 which indicates the experience for both groups is almost the same.
- **Indicator 7 - Percentage believing the Trust provides equal opportunities for career progression or promotion.**

The percentage of ethnic minority colleagues reporting they believe there are equal opportunities for career development or promotion has improved once again from the previous year, from 49.7%. to 50.8% The disparity ratio has also reduced to 1.17 indicating there is no adverse impact on colleagues from ethnic minority groups.

- **Indicator 8 – Percentage of colleagues experiencing discrimination from managers or colleagues.** The percentage of ethnic minority colleagues reporting they've experienced discrimination from managers or colleagues has improved slightly since last year from 15.6% to 14.3%. The disparity ratio remains high at 2.27 indicating that ethnic minority colleagues are more than twice as likely to report experiencing discrimination from managers or colleagues than white colleagues. This is an area which has not fallen within the 0.80-1.25 disparity range since reporting began in 2016 and is an area we must seek to improve urgently over the coming year.
- **Indicator 9 – Ethnic diversity of Voting Board Members**. At present there is 1 voting Board member who belongs to an ethnic minority group which is an improvement on the previous year, however action needs to be taken to further enhance the diversity of our Board so it is proportionately representative of our wider workforce and community.

The following indicator shows a **deterioration** in the experience of our Ethnic Minority colleagues;

- **Indicator 1 – Representation.** Action is needed to increase the representation of ethnic minority colleagues in more senior roles.
- **Indicator 2 – Relative likelihood of appointment from shortlisting.** The metric score has worsened from last year illustrating white colleagues are now 1.5 times more likely to be appointed from shortlisting.
- **Indicator 3 – Likelihood of entering a formal disciplinary process.**

  This metric has deteriorated since last year but still falls within the 0.80-1.25 range indicating there is no adverse impact for ethnic minority colleagues.
- **Indicator 4 – Access to non-mandatory training and continuous professional development.** This metric has decreased slightly since last year. The race disparity ratio is 1.09 and indicates the experience for both white and ethnic minority colleagues is almost the same.

INDICATOR 1 – REPRESENTATION

This section details the percentage of colleagues in each of the AFC bands 1-9 and VSM for both clinical and non-clinical colleagues from white and ethnic minority backgrounds compared with colleagues in the overall workforce. As of 31 March 2025, the Trust Headcount was 9,471. White 6569 (69.4%), ethnic minority 2787 (29.4%), unknown 115 (1.2%). A key aspect to note is the reduction in overall workforce numbers from 2024 (10,323) to 2025 (9471), most of which have been seen across the non-clinical workforce as this has impacted the percentage representation of ethnic minority colleagues across bands 4 – 8c, some of this reduction will have been through the transfer of colleagues to One LSC.

As detailed below the greatest representation of ethnic minority colleagues in non-clinical roles are in bands 2 and below (below band 1 tend to be apprentices). Across the remaining bands (band 3 and above) ethnic minority colleagues are under-represented when compared against the Trust wide ethnic minority workforce.

From a clinical workforce perspective, the highest percentage of ethnic minority colleagues can be found in band 5 roles. Aside from band 5 and band 2 clinical roles, ethnic minority colleagues are under-represented in all other bands when compared against the overall clinical ethnic minority workforce.

It is positive to note that in clinical and non-clinical roles we have seen an increase in the overall percentage of ethnic minority colleagues. Areas for improvement are to increase the percentage of ethnic minority colleagues in more senior roles 8a and above, specifically in band 9 and VSM roles.

Agenda for Change Workforce

Non-Clinical	% Ethnic Minority Background 2025	% Ethnic Minority Background 2024	Clinical	% Ethnic Minority Background 2025	% Ethnic Minority Background 2024
Under Band 1	-	71.4	**Under Band 1**	11.1	75.0
Band 1	33.3	33.3	**Band 1**	-	-
Band 2	30.7	27.9	**Band 2**	31.8	26.3
Band 3	15.1	16.4	**Band 3**	16.6	16.0
Band 4	9.8	11.3	**Band 4**	11.0	11.6
Band 5	6.3	11.9	**Band 5**	49.0	49.5
Band 6	7.7	12.9	**Band 6**	21.1	19.5
Band 7	2.9	10.7	**Band 7**	10.3	9.2
Band 8a	3.1	6.4	**Band 8a**	12.1	11.0
Band 8b	-	8.3	**Band 8b**	4.8	6.9
Band 8c	5.6	13.8	**Band 8c**	-	4.6
Band 8d	11.1	7.1	**Band 8d**	8.3	7.7
Band 9	-	-	**Band 9**	-	-
VSM	-	-	**VSM**	-	-
Total	**19.4**	**18.9**	**Total**	**29.4**	**27.3**

Medical and Dental Workforce

Role	% Ethnic Minority Background 2025	% Ethnic Minority Background 2024
Consultants	53.5	52.7
Of which Senior Medical Manager	46.6	42.2
Non-consultant career grade	67.7	71.0
Trainee grades*	72.3	76.7

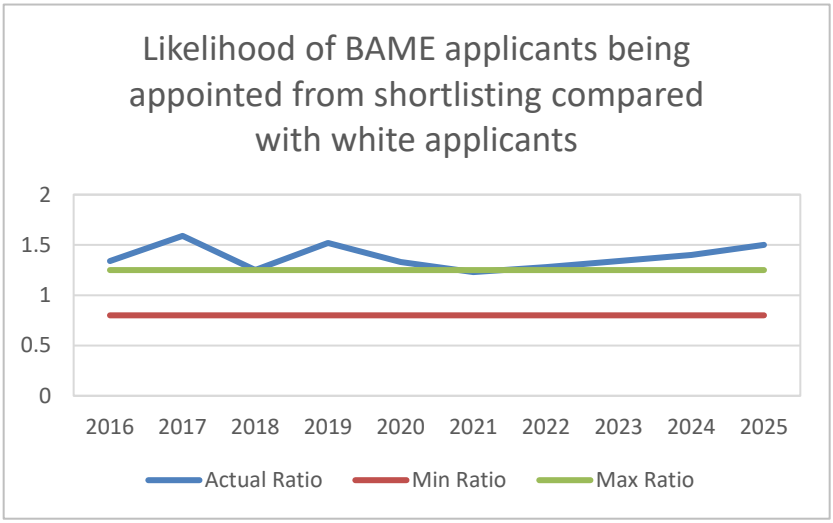
*Excludes Lead Employer Medical and Dental Trainees

The medical and dental workforce has a higher proportion of ethnic minority colleagues in most roles, other than Senior Medical Manager, than white colleagues.

INDICATOR 2 – LIKELIHOOD OF APPOINTMENT FROM SHORTLISING

The table below, indicates the likelihood of white and ethnic minority candidates being appointed from shortlisting. The race disparity ratio for this indicator has deteriorated, moving to 1.5 (from 1. 4). This means white candidates are 1.5 times more likely to be appointed from shortlisting than candidates from an ethnic minority group. The disparity ratio is above the range of 0.8 – 1.25, the graph below illustrates that it has exceeded the disparity ratio range since 2022 and is deteriorating each year therefore further action needs to be taken.

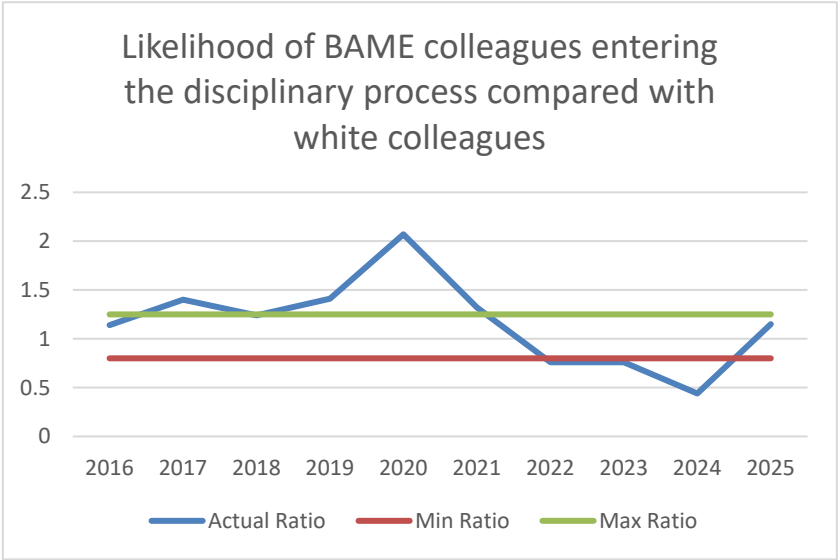
	2024		2025	
	White (n=)	**Ethnic Minority Background (n=)**	**White (n=)**	**Ethnic Minority Background (n=)**
Number of shortlisted applicants	4956	3450	2714	2606
Number appointed from shortlisting	1745	865	1015	657
Relative likelihood of appointment	35.2%	25.1%	37.4%	24.9%
Disparity ratio	**1.4**		**1.5**	



INDICATOR 3 – LIKELIHOOD OF ENTERING FORMAL DISCIPLINARY PROCESSES

The data displayed in the table below shows that for this reporting year we have seen the disparity ratio increase. In a reverse of the trend since 2020 (illustrated in the graph below), this indicates that ethnic minority colleagues are slightly more likely to enter the disciplinary process, it remains within the disparity ratio boundaries of 0.8 – 1.25 meaning this is not a priority area for action in this reporting year.

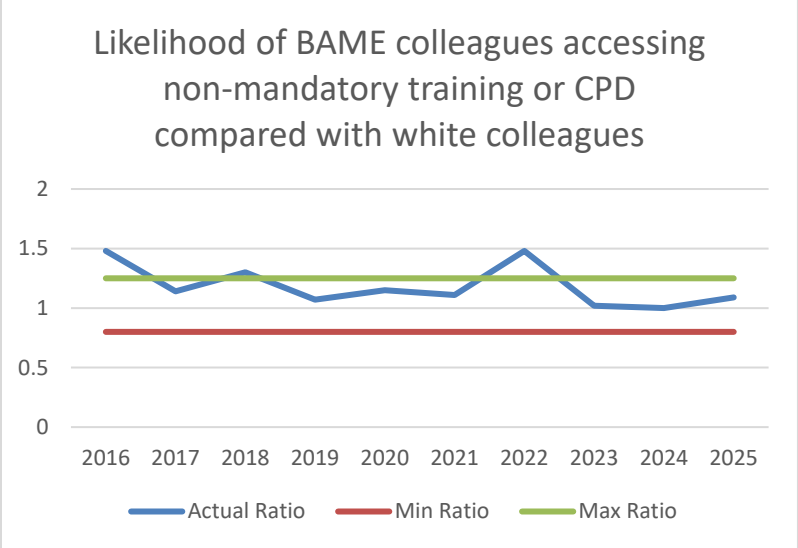
	2023 - 2024		2024 - 2025	
	White (n=)	Ethnic Minority Background (n=)	White (n=)	Ethnic Minority Background (n=)
Number of colleagues entering the disciplinary process	67	11.5	41	20
Disparity ratio	**0.44**		**1.15**	



INDICATOR 4 – ACCESS TO NON-MANDATORY TRAINING AND CONTINUOUS PROFESSIONAL DEVELOPMENT

The results for this indicator show that a greater percentage of colleagues across both groups have accessed non-mandatory training and CPD over the past 12 months; there has been a slightly greater increase in the percentage of white colleagues which is reflected in the rise of the disparity ratio to 1.09 from 1.00 last year. The disparity ratio is still within the 0.80 - 1.25 range as it has been for the past few years. Since 2024 the data now includes continuous professional development education activities which have been funded through Health Education England.

	2024		2025	
	White (%)	Ethnic Minority Background (%)	White (%)	Ethnic Minority Background (%)
Percentage of colleagues accessing non-mandatory training and CPD	22.8%	22.7%	26.6%	24.5%
Disparity ratio	**1.00**		**1.09**	



INDICATOR 5 – BULLYING AND HARRASSMENT FROM THE PUBLIC

As displayed in the organisation data for this indicator (taken from the National Staff Survey 2024 Results) 20.7% of ethnic minority staff and 22.6% of white colleagues have reported experiencing bullying, harassment or abuse from patients, relatives or other members the public in the last 12 months. The four-fifths rule calculation (0.91) indicates there is no adverse impact for ethnic minority colleagues for this indicator; whilst the experience of White colleagues has deteriorated, the experience for Ethnic Minority colleagues has improved. The percentage of colleagues reporting bullying and harassment, in addition to our disparity ratio, are lower than the national benchmarks.

Organisation Data for 2024 and National Benchmark Comparator

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	22.6%	20.7%	0.91	Improvement
National Benchmark	23.2%	28.3%	1.21	

Performance for this indicator, as shown in the table below, demonstrates a relatively consistent picture from disparity ratio perspective over the last 6 years with the range consistently between 0.75 – 1.03.

Organisation Data Over Time

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
2024	22.6%	20.7%	0.91	Improvement
2023	21.7%	22.5%	1.03	Deterioration
2022	21.2%	17.2%	0.81	Deterioration
2021	21.6%	16.2%	0.75	Improvement
2020	22.5%	19.5%	0.87	Deterioration
2019	25.6%	19.5%	0.76	Improvement

Ethnic Group National Staff Survey Data for the past 3 years

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2024	**n = 3996**	**n = 610**	**n = 104**	**n = 75**	**n = 32**	**n = 3138**
	22.2% ↑	18.7% ↓	26.9% ↓	32.0% ↑	12.5% ↓	22.6% ↑
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	21.8%	20.5%	29.2%	27.8%	26.3%	21.7%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	20.4%	17.5%	18.6%	15.8%	13.3%	21.2%

From reviewing National Staff Survey Data for this WRES indicator by ethnic minority group it was found the experience for two groups is reflecting a deterioration from 2023 (Mixed, Multiple Ethnic colleagues and White colleagues). The group with the greatest percentage of colleagues reporting they've experienced bullying, harassment or abuse from the public over the last 12 months is Mixed/Multiple Ethnic colleagues and the group with the lowest percentage of colleagues reporting they've experienced bullying, harassment or abuse from the public over the last 12 months is Other Ethnic group colleagues.

The greatest difference in responses from 2023 to 2024 is seen in the percentage of Other Ethnic group colleagues reporting experiencing bullying, harassment or abuse from the public – this has reduced by 13.8%.

INDICATOR 6 – BULLYING AND HARRASSMENT FROM COLLEAGUES

The data displayed below for indicator 6, highlights an improvement from last year's WRES reporting position with a disparity ratio of 1.01 for colleagues experiencing harassment, bullying or abuse from colleagues in the last 12 months. As the 1.14 ratio falls between 0.8 and 1.25, it indicates there are no adverse impacts for ethnic minority colleagues. Our disparity ratio is similar to the national benchmark, although the percentage of Ethnic Minority colleagues experiencing bullying and harassment from other colleagues is lower than the national benchmark.

Organisation Data for 2024 and National Benchmark Comparator

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	21.1%	21.3%	1.01	Improvement
National Benchmark	21.5%	24.8%	1.15	

As reflected in the table below, performance for this indicator over the last 5 years indicates a mixed picture and inconsistent patterns or trends, with some years seeing improvements and other years seeing a deterioration in both the disparity ratio and the percentage of colleagues reporting they have experienced bullying and harassment from other colleagues. The disparity ratio has consistently remained between the 0.8-1.25 range across the last 6 years.

Organisation Data Over Time

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
2024	21.1%	21.3%	1.01	Improvement
2023	20.4%	23.4%	1.14	Deterioration
2022	20.9%	22.7%	1.08	Deterioration
2021	20.3%	18.2%	0.90	Improvement
2020	23.6%	26.2%	1.11	Deterioration
2019	25.9%	24.0%	0.93	Improvement

Ethnic Group National Staff Survey Data for the past 3 years

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2024	**n = 3996**	**n = 610**	**n = 104**	**n = 75**	**n = 32**	**n = 3138**
	21.2% ↑	19.3% ↓	22.1% ↓	32.0% ↑	31.3% ↑	21.1% ↑
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	21.1%	22.9%	22.6%	31.9%	18.9%	20.4%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	21.3%	**22.3%**	**23.2%**	**23.4%**	**25.8%**	**20.8%**

From reviewing the ethnicity group data set for this WRES indicator, it was found that colleagues who identified as being from Mixed/ Multiple ethnic group background reported the greatest incidence of bullying, harassment and abuse from colleagues with 32.0% reporting one or more incident - this is consistent with last years' data (31.9%). Colleagues in the Other ethnic groups category have reported a 12.4% increase on last year's data.

INDICATOR 7 – CAREER PROGRESSION AND PROMOTION

The data for this indicator shows 50.8% of ethnic minority colleagues and 59.5% of white colleagues believe our organisation provides equal opportunities for career progression and promotion. The disparity ratio of 1.17 is within the recommended range and indicates there is no potential adverse impact for colleagues from an ethnic minority background. Our staff survey results and disparity ratio for this metric are almost the same as the national benchmarks.

Organisation Data for 2024 and National Benchmark Comparator

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	59.5%	50.8%	1.17	Improvement
National Benchmark	58.8%	49.7%	1.18	

Performance for this indicator as indicated in the table below has remained fairly static over the last 6 years, seeing a sustained improvement since 2022 following a dip in 2021. The disparity ratio range for this metric over the last 6 years is 1.17-1.33.

Organisation Data Over Time

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
2024	59.5%	50.8%	1.17	Improvement
2023	62.4%	49.7%	1.25	Improvement
2022	62.0%	48.5%	1.28	Improvement
2021	60.7%	45.5%	1.33	Deterioration
2020	62.4%	49.5%	1.26	Same
2019	62.4%	49.7%	1.26	Improvement

Ethnic Group National Staff Survey Data for the past 3 years

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2024	**n = 3996**	**n = 610**	**n = 104**	**n = 75**	**n = 32**	**n = 3138**
	57.4% ↓	54.3% ↑	40.8% ↓	40.0% ↓	41.9% ↑	59.5% ↓
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	59.2%	51.5%	43.1%	47.9%	41.7%	62.4%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	59.2%	49.6%	44.8%	42.1%	45.2%	62.0%

The National Staff Survey data when broken down by ethnic minority group found that colleagues from Mixed/Multiple Ethnic groups were most likely to state they did not believe there were equal opportunities for career progression or promotion, furthermore the percentage had decreased by 7.9% on the previous year's results. The category of Asian/Asian British colleagues has seen the biggest positive increase in response (2.8% from last years' data).

INDICATOR 8 – EXPERIENCE OF DISCRIMINATION FROM MANAGER OR COLLEAGUES

The table below displaying the Organisation Data for indicator 8 shows that 14.3% of ethnic minority colleagues and 6.3% of white colleagues have reported experiencing discrimination at work from a manager, team leader or other colleagues through the national Staff Survey. This leads to a disparity ratio of 2.26 which indicates there is likely to be a considerable negative impact for ethnic minority group colleagues for this indicator. The disparity ratio for this indicator is the worst out of all the WRES indicators measured, has consistently remained outside of the recommended disparity range since

2019, therefore improvement work needs to continue and further develop as a matter of urgency to reduce discrimination experienced by colleagues from ethnic minority backgrounds.

Organisation Data for 2024 and National Benchmark Comparator

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	6.3%	14.3%	2.26	Improvement
National Benchmark	6.7%	15.7%	2.34	

This year we have seen a slight improvement in the disparity ratio for this metric, as the experience for White colleagues has deteriorated whilst the experience for Ethnic Minority colleagues has improved. The results across the last 6 years have remained fairly static aside from a notable increase in ethnic minority colleagues reporting discrimination in 2020 and 2023.

Organisation Data Over Time

	White	Ethnic Minority Background	Disparity Ratio	Change From Previous Year
2024	6.3%	14.3%	2.26	Improvement
2023	5.5%	15.6%	2.84	Deterioration
2022	6.5%	12.9%	1.98	Deterioration
2021	6.9%	12.5%	1.81	Improvement
2020	6.0%	17.6%	2.94	Deterioration
2019	5.8%	12.9%	2.22	Deterioration

Ethnic Group National Staff Survey Data for the past 3 years

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2024	**n = 3996**	**n = 610**	**n = 104**	**n = 75**	**n = 32**	**n = 3138**
	8.1% ↑	13.8% ↓	18.6% ↑	10.7% ↓	18.8% ↑	6.3% ↑
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	7.7%	15.6%	17.8%	17.1%	2.7%	5.5%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	7.9%	13.4%	15.6%	10.4%	10.0%	6.5%

When the experience of different ethnic minority groups was reviewed as detailed in the National Staff Survey data, it was found that colleagues who are from Other ethnic groups and Black/African/Caribbean/Black British groups report experiencing the most discrimination with 18.8% and 18.6% respectively stating they have personally experienced discrimination from their manager or colleagues over the last 12 months. Colleagues who identify as 'Mixed/Multiple Ethnic groups' reported a marked decrease of 6.4% from the previous year.

INDICATOR 9 – BOARD MEMBERSHIP

Whilst we have 1 voting Board member who belongs to an ethnic minority group which equates to 7.69%; compared with an overall workforce representation of 29.4% this means representation is 21.7% lower than our workforce and is therefore not proportionately representative. We do not have any ethnic minority group representation across our 9 Executive Board members, meaning the representation is 29.4% lower than our workforce.

WRES ACTION PLAN

Nationally, NHS England have set six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The improvement plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although it is not limited to these groups) and links to the NHS People Plan. The six actions are as follows, all of which have been built into our strategic EDI action plan:

1) Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3) Develop and implement an improvement plan to eliminate pay gaps.
4) Develop and implement an improvement plan to address health inequalities within the workforce.
5) Implement a comprehensive induction, onboarding and development programme for internationally recruited colleagues.
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

These actions are supported by the NHS Race & Health Observatory's (RHO) strategic plan for 2024-2027 to 'Empower People to deliver Health Equity' through tackling disparities in pay and progression; setting targets for bullying and harassment and promoting a more diverse and inclusive leadership in the NHS.

Organisations are mandated to produce a detailed WRES action plan, elaborating on the priority areas identified in this report and setting out the next steps with milestones for expected progress against the WRES indicators. The actions will be formulated in conjunction with colleagues who participate in the organisation's Ethnicity Ambassador Forum and will be incorporated within both the Equality, Diversity and Inclusion Strategic Action Plan and the dedicated workforce focused actions as outlined in Our People Plan (which is the Workforce and Organisational Development Strategy for the strategic aim To Be Supportive and Inclusive).

In addition to the Trust wide EDI Strategy and People Plan, we are working collaboratively with the Lancashire and South Cumbria Integrated Care Board (ICB) Belonging Delivery Group. There is an ICB Belonging Group focus on improving the following key WRES metrics that are again aligned with the Trust's EDI action plan:

- Increase diverse recruitment from shortlisting
- Reduction in bullying and harassment from the public and patients
- Equal board representation

An additional related piece of work which has been undertaken at a regional level is in respect of the NorthWest Black, Asian and Minority Ethnic Assembly Anti-Racist Framework which encourages organisations to take an unapologetically anti-racist stance, taking positive action to eliminate racism across NHS organisations. The five anti-racist principles are;

1) Prioritise Anti-Racism
2) Understand Lived Experience
3) Grow Inclusive Leaders
4) Act to Tackle Inequalities
5) Review Progress Regularly

These principles are supported by an assessment framework which is organised into three levels of achievement; Bronze, Silver and Gold, with each level building on the next. Each level contains a number of actions which organisations must evidence in order to be 'accredited' as working at that level. Our aim is to create a working group including colleagues from the Ethnicity forum, to help progress our evidence gathering and application to achieve Bronze level accreditation.

The strategic action plan will address the priority areas for improvement as found through the analysis of our data against the 9 WRES indicators alongside the views, ideas and actions valued by colleagues in the Ethnic Minority Inclusion Forum. For clarity the areas of focus in the strategic action plan for the next 12 months to support WRES improvements are:

- Increasing the likelihood of candidates from an ethnic minority background being appointed from short listing across all posts/bands.
- Increase the percentage of colleagues from an ethnic minority background occupying more senior roles (specifically Band 9, VSM and voting Board member roles).
- Reducing the percentage of colleagues from an ethnic minority background experiencing discrimination at work from their manager, team leader or other colleagues

Work has already commenced to support inclusive recruitment with a full review of the recruitment process being undertaken (in conjunction with the Head of Recruitment) to identify areas where there may be the potential for bias to occur and identifying mitigating actions. An ICB wide project, led by Lancashire Teaching Hospitals, in respect of Cultural Awareness is also nearing completion – the view being that this will be rolled out across all organisations in the ICB. Conversations have taken place with our Chief People Officer, the Chair of the Ethnicity forum, the Head of Diversity & OD and a union representative to discuss career progression, diversity at senior levels and the experience and career pathways of our Internationally Educated colleagues.

Some actions scheduled for progression over the next twelve months are to; review the Trust values ensuring that inclusive behaviours are made more explicit, design an Inclusive Language guide to support colleagues to have inclusive and psychologically safe conversations with colleagues and patients which are free from fear around saying the 'wrong' thing, complete the work in relation to Inclusive Recruitment processes and practices, develop an Equality Representatives training module which supports colleagues in recruiting and managing formal workforce processes without bias. Design a talent management strategy that targets under-representation and lack of diversity at senior levels, specifically addressing issues around attracting and retaining younger talent as well as ensuring equity of career progression opportunities for staff of all protected characteristics (particularly internationally recruited staff) and to develop and deliver a comprehensive development programme for internationally recruited colleagues.

Next steps:

- To share this report with the Ethnic Minority Inclusion Forum to seek their views and lived experience in relation to these findings as well as to understand additional actions they believe will help to reduce inequality and increase inclusion.
- To consult and co-produce with the Ethnic Minority Inclusion Forum on the strategic action plan for equality, diversity and inclusion and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.

- Communicate results and action plan to our workforce through
    - Sharing results and actions with the Equality, Diversity and Inclusions Steering Group, for consideration as to how themes from the WRES report can support both corporate and divisional levels actions.
    - Sharing through Divisional Workforce Committee meetings.
    - Sharing further updates with the Ethnic Minority Inclusion forum.
    - Managers Update Sessions.
    - Specific organisation wide communications in conjunction with the Communications team.
- Publish our results and action plan externally on the Trust website
- The strategic action plan will be implemented, with progress measured through the Equality Strategy Group and outcomes will be reviewed utilising the Staff Survey in conjunction with workforce data results.

FINANCIAL IMPLICATIONS

Research evidence indicates that, when ethnic minority colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all colleagues have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice. There are a number of risks which are impacting on our ability to deliver actions at pace against this agenda, this include the lack of dedicated staffing resources for the EDI agenda.

The size and scale of the programmes of work to deliver improvements for ethnic minority groups is significant, especially when considered next to and needing to balance progress for colleagues with other protected characteristics. Combined with the level of understanding by the wider workforce with regards to their role in also delivering improvements for ethnic minority colleagues, this work predominantly falls to the colleagues within Organisational Development – EDI team to drive forward transformation, increase awareness whilst supporting individual colleagues who have had negative experiences in their place of work.

IMPACT ON STAKEHOLDERS

There is a wide body of research evidence within the NHS which tells us that the experiences of our ethnic minority colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our ethnic minority colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Board of Directors

- Receives and notes the report.
- Approve the report for publishing report externally.

THE WORKFORCE RACE EQUALITY STANDARD 2025

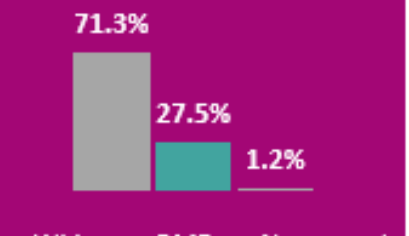
Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

The NHS Workforce Race Equality Standard (WRES) was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. There are nine WRES indicators. The infographic (for 2025) below highlights any differences between the experience and treatment of White colleagues and Ethnic Minority colleagues, as an organisation we are committed closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION



APPOINTMENTS

White candidates are **1.5** times more likely than **ethnic minority** candidates to be appointed from shortlisting

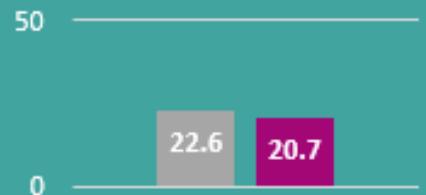
DISCIPLINARY PROCESS

Ethnic minority colleagues are **1.15** times more likely to enter a formal disciplinary process than **white** colleagues

TRAINING AND DEVELOPMENT

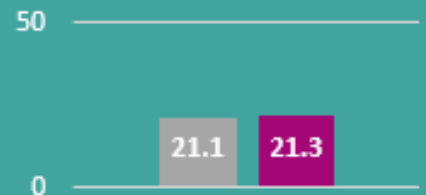
White colleagues are slightly more likely **1.09** to access non-mandatory training and CPD compared to ethnic minority colleagues

BULLYING AND HARRASSMENT FROM PATIENTS AND THE PUBLIC



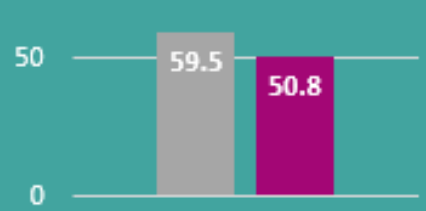
20.7% of Ethnic Minority colleagues experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months

BULLYING AND HARRASSMENT FROM COLLEAGUES



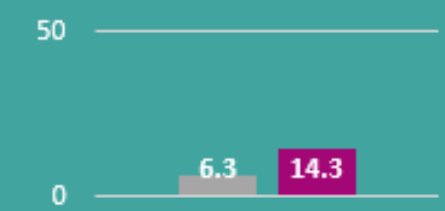
21.3% of **Ethnic Minority** colleagues experienced harassment, bullying or abuse from other colleagues in the last 12 months

CAREER PROGRESSION



50.8% of **Ethnic Minority** colleagues believe the Trust provides equal opportunities for career progression or promotion

DISCRIMINATION



14.3% of **Ethnic Minority** colleagues reported experiencing discrimination from their manager / team leader / colleagues within last 12 months

BOARD MEMBERSHIP

1 Board Member identifies as belonging to an ethnic minority group, out of a total of 17 Board Members

10.2B - WDES

REFERENCES

Only PDFs are attached

10.2b - WDES 2025.pdf

Board of Directors

Workforce Disability Equality Standard (WDES) Submission 2025

Report to:	Workforce Committee	**Date:**	3rd June 2025
Report of:	Chief People Officer	**Prepared by:**	M. Davis

Purpose of Report

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

Executive Summary:

The purpose of this report is to share the data which will form the submission and subsequent publication of the 2025 Workforce Disability Equality Standard (WDES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest staff survey. The Board are asked to review and approve the contents of the report for publication and to consider the areas for action and associated next steps which are to consult with the Disability Inclusion Forum with regards to the results, understand their lived experience, the actions which will make the greatest impact and to seek feedback on the draft action plan, making changes where necessary.

The priority areas recommended for action are those which are indicating disabled colleagues are being adversely impacted or disadvantaged according to the four-fifths rule are:

Metric 3 – Likelihood of colleagues with a disability entering the formal capability process.

Metric 4a – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.

Metric 4b – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from managers.

Metric 4c - Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from colleagues.

Metric 7 - Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work.

It is recommended that the Board of Directors

Receives and notes the report.

Approve the report for publishing report externally.

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			
Workforce Committee – 13th May 2025			

INTRODUCTION

The Workforce Disability Equality Standard (WDES) is a mandated requirement through the NHS standard contract which was launched in April 2019, making this the seventh WDES report. Organisations are instructed to report and publish their WDES data on an annual basis, illustrating organisational progress against ten indicators relating to workforce disability equality.

RESULTS

For each of the indicators the data is compared for Disabled colleagues and non-disabled colleagues. National staff survey averages and organisational results for the last 6 years have been included for comparative purposes where applicable to the metric being reviewed.

	Total Org Response	Non-disabled colleagues	Disabled colleagues
2024	3996	2832	1084
2023	4539	3268	1149
2022	4440	3399	996
2021	4311	3069	998

The table above shows the numbers of colleagues completing the staff survey each year. In 2024 the total number of colleagues who completed the staff survey dropped by 12% overall; whilst there were slightly less Disabled colleagues who completed, the percentage reduction only equated to 5.5%. What we don't yet understand is what percentage of colleagues who are invited to complete the staff survey each year, use the opportunity to share their views and experiences. This is something we are hoping to be able to understand working with the OD Projects team moving forwards.

Summary Data

The approach used by the national equality teams is to utilise the four-fifths (or "80 percent") rule to highlight whether practices may be having an adverse impact on an identified group, e.g. colleagues with a disability. For example, if the relative likelihood of an outcome for one sub-group compared to another is **less than 0.8 or higher than 1.25**, then the process would be identified as potentially having an adverse impact on one of those sub-groups. This will be referred to as the Disparity Ratio throughout the report.

Improvements have been seen for Disabled colleagues across the following indicators;

- **Metric 1 – Representation**, we have seen some increases in the percentage of disabled colleagues across our workforce as a whole. Whilst there is much more work to do to increase disclosure of disability and supporting disabled colleagues to progress we are making small steps forward.
- **Metric 2 – likelihood of appointing disabled candidates from shortlisting.** This has improved slightly this year and remains within the expected disparity ratio range of 0.8-1.25.
- **Metric 3 – Likelihood of entering formal capability process** The disparity ratio has improved this year from 2.07 in 2023/24 to 1.98 in 2024/25, whilst the position has improved the data still indicates there is likely to be an adverse impact on disabled colleagues entering the formal capability process.
- **Metric 4b – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from managers.** The disparity ratio still indicates a likely adverse impact on disabled colleagues, however the percentage of disabled colleagues reporting experiencing this has marginally improved since last year.

- **Metric 4d - Percentage of colleagues saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.** This score has both improved since last year and remains within the disability disparity ratio boundaries to indicate no adverse impact for disabled colleagues.
- **Metric 5 - Percentage believing the trust provides equal opportunities for career progression or promotion.** This score has declined marginally for disabled colleagues since last year, the decline in staff survey responses has been greater for non-disabled colleagues which means the disparity ratio has improved and continues to indicate no adverse impact for disabled colleagues.
- **Metric 6 – Percentage of colleagues who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** This score has improved for disabled colleagues whilst declining for non-disabled colleagues meaning that the disparity ratio has improved on last year, and now falls within the disparity ratio range indicating that there is no adverse impact for colleagues who are disabled.
- **Metric 8 - Percentage of disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.** This score has improved again this year and remains above the Picker national average.
- **Metric 10 – Board Representation.** 11.1% of voting Board members identify as having a disability, this is similar to last year and above the NHS national average.

The following indicator shows a **deterioration** in the experience of our Disabled colleagues;

- **Metric 4a – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.** The staff survey responses for disabled colleagues has deteriorated slightly from 2023 (27.7% - 28.1%) which has also led to a slight increase in the disparity ratio. This remains outside of the 0.80-1.25 range indicating a likely negative impact on disabled colleagues.
- **Metric 4c - Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from colleagues.** The disparity ratio indicates a negative impact on disabled colleagues, as the staff survey results for disabled colleagues have declined slightly.
- **Metric 7 - Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work.** This disparity ratio has improved since last year (1.34 from 1.37) despite their being a deterioration in the percentage of disabled colleagues being satisfied with the extent their work is valued, there has been a greater deterioration for non-disabled colleagues. It remains above the disparity ratio boundaries to indicate there is an adverse impact for disabled colleagues.
- **Metric 9 – Staff Engagement**. The disparity ratio has remained the same this year, despite the engagement score deteriorating, it shows no adverse impact for disabled colleagues

METRIC 1 – REPRESENTATION

This section details the percentage of colleagues in each of the AFC bands 1-9 and VSM for both clinical and non-clinical colleagues who are disabled and non-disabled compared with colleagues in the overall workforce.

Currently we know that 587 of our colleagues have recorded they have a long-term condition or disability with ESR which equates to 5.7% of our workforce. We understand from the most recent National Staff Survey completion however that 27.1% of colleagues who took part in the staff survey indicated they have a long-term condition/disability (at least 1084 colleagues). If these colleagues updated ESR to reflect their long-term condition/disability, this would help to support more accurate data for the non-staff survey metrics i.e. 1 and 3.

As displayed in the table below, disabled colleagues have stronger representation in non-clinical roles which are at band 3 - 5, 8a, 8b and VSM. We have seen an increase in the percentage of disabled colleagues across most bands other than band 6, 8b/8c which has seen a slight decrease. Of note is the band 3 which shows an increase of over 2%.

For clinical roles, there has been some level of increase in disabled colleague representation across most bands in comparison to 2024 data. For both clinical and non-clinical roles we need to take action to improve the percentage of disabled colleagues in more senior level roles, particularly at band 8d/9 where there is currently no representation.

Agenda for Change Workforce

Non-Clinical	% Disabled 2025	% Disabled 2024	Clinical	% Disabled 2025	% Disabled 2024
Under Band 1	100%	14.3%	**Under Band 1**	11.1%	25.0%
Band 1	-	-	**Band 1**	-	-
Band 2	5.7%	5.0%	**Band 2**	6.8%	6.5%
Band 3	9.6%	7.0%	**Band 3**	7.6%	6.6%
Band 4	8.8%	7.2%	**Band 4**	9.8%	9.7%
Band 5	8.5%	7.9%	**Band 5**	5.5%	4.5%
Band 6	2.6%	3.6%	**Band 6**	7.0%	6.8%
Band 7	5.7%	5.7%	**Band 7**	5.6%	4.2%
Band 8a	9.4%	8.5%	**Band 8a**	6.7%	5.9%
Band 8b	6.7%	8.3%	**Band 8b**	1.6%	1.7%
Band 8c	5.6%	6.9%	**Band 8c**	5.3%	4.5%
Band 8d	-	-	**Band 8d**	-	-
Band 9	-	-	**Band 9**	-	-
VSM	14.3%	10.0%	**VSM**	50%	50.0%
Total	5.9%	6.1%	**Total**	5.7%	5.8%

With regards to the Medical and Dental Workforce, there are limited levels of self-declaration of long-term condition, illness of disability, as illustrated in the table below. Furthermore the figures for consultants and non-consultant career grades has remained static from 2024, however we have seen a notable increase in the percentage of trainee grades disclosing a long-term condition or disability. Work needs to be undertaken with this workforce group to encourage self-reporting, changing perceptions or stigma around disclosing a disability and creating feelings of psychological safety in sharing this information with us as an employer.

Medical and Dental Workforce

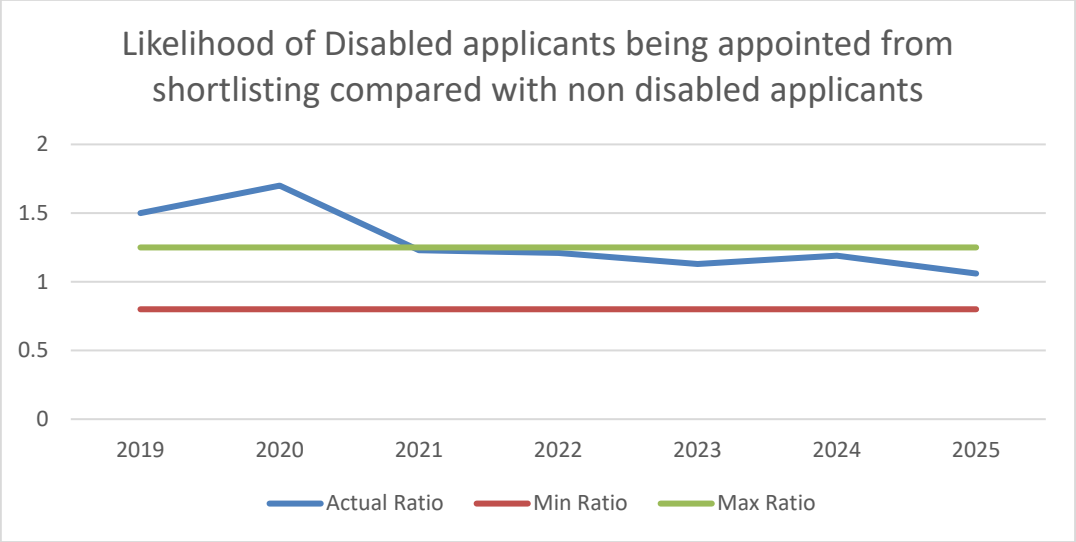
Role	% Disabled Background 2025	% Disabled Background 2024
Consultants	0.8%	0.8%
Non-consultant career grade	3.2%	3.2%
Trainee grades*	4.2%	2.8%

*Excludes Lead Employer Medical and Dental Trainees

METRIC 2– LIKELIHOOD OF APPOINTMENT FROM SHORTLISTING

The table below, indicates the likelihood of disabled candidates being appointed from shortlisting. The disparity ratio for this indicator has improved since last year, moving from 1.19 in 2024 to 1.06 in 2024 this remains within the disparity ratio boundary of 0.80-1.25 indicating there's no adverse impact on disabled colleagues. As can be seen from the graph, the disparity ratio for this metric is improving and has consistently fallen within the 0.80-1.25 range since 2021.

	2023 - 2024		2024-2025	
	Disabled (n=)	Non-Disabled (n=)	Disabled (n=)	Non-Disabled (n=)
Number of shortlisted applicants	746	7601	474	4823
Number appointed from shortlisting	197	2388	140	1516
% appointed from shortlisting	26.40%	31.41%	29.53%	31.43%
Disparity ratio	**1.19**		**1.06**	

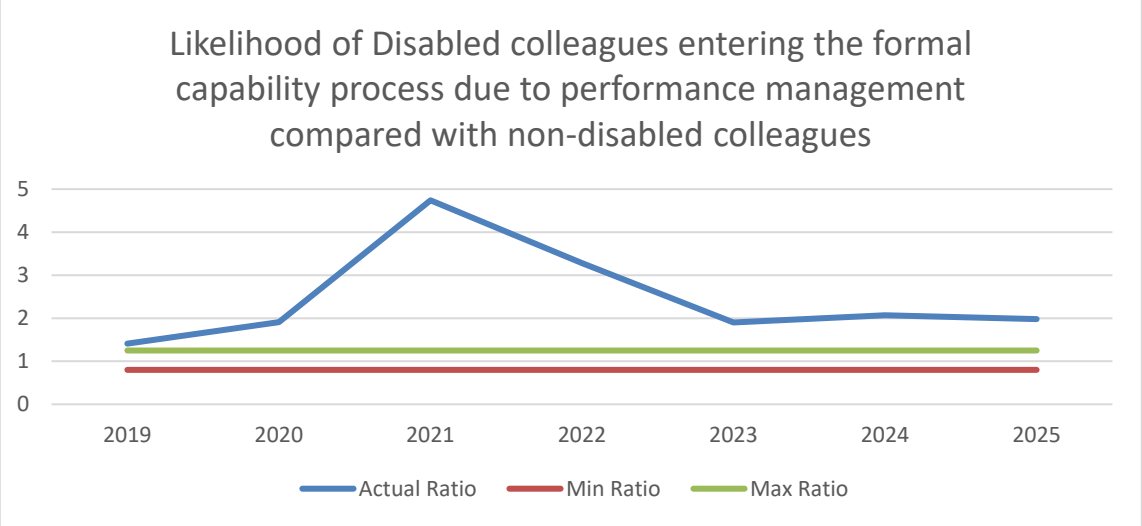


METRIC 3 – LIKELIHOOD OF ENTERING FORMAL CAPABILITY PROCESSES

Metric 3 indicates disabled colleagues are 1.98 times more likely to enter the formal capability process, a slight improvement from last year's results. This remains an area for focused action as it falls outside of the 0.8-1.25 disparity ratio. NB - the average cases for this metric continue to be very low in number therefore care must be taken before drawing a conclusion; across 2024 - 2025 there was an average of 25 formal capability cases per year involving disabled staff and an average of 130 for non-disabled colleagues.

	2023 - 2024		2024-2025	
	Disabled (%)	Non-Disabled (%)	Disabled (%)	Non-Disabled (%)
% of colleagues entering the formal capability process	0.87%	0.42%	1.71%	0.86%
Disparity ratio	**2.07**		**1.98**	

As can be seen from the graph below, this is a metric which has never sat within the 0.8-1.25 disparity ratio guidelines since reporting for the WDES began, whilst it peaked in 2021 it has reduced since then and has been relatively stable over the past 3 years, albeit still outside of the disparity range.



METRIC 4 – BULLYING, HARASSMENT OR ABUSE

METRIC 4A – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM PATIENTS, SERVICE USERS OR THE PUBLIC IN THE LAST 12 MONTHS

The data displayed overleaf highlights a deterioration from last year's WDES report as the staff survey results show slightly more disabled and non-disabled colleagues reporting they have experienced bullying, harassment or abuse from patients, service users or the public. With a disparity ratio of 1.40, this is likely to have an adverse impact for colleagues with a disability or LTC compared with colleagues without a disability or LTC as it falls outside of the four-fifths range of 0.8 – 1.25.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	28.1%	20.0%	1.40	Deterioration
National Benchmark	29.4%	22.7%	1.30	

Performance for this indicator as indicated in the table overleaf indicates this continues to be an area for improvement.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	28.1%	20.0%	1.40	Deterioration
2023	27.7%	19.9%	1.36	Improvement
2022	27.0%	18.5%	1.46	Improvement
2021	27.7%	18.7%	1.48	Deterioration
2020	27.1%	20.8%	1.30	Deterioration
2019	30.6%	23.6%	1.29	Improvement
2018	34.5%	24.0%	1.44	-

METRIC 4B – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM MANAGERS IN THE LAST 12 MONTHS

The data displayed below focuses on colleagues who have experienced harassment, bullying or abuse from managers. The disparity ratio shows disabled colleagues are 1.68 times more likely to report experiencing harassment, bullying or abuse from managers in the last 12 months than non-disabled colleagues. The experience of colleagues within our organisation is better than the national benchmark data (11.3% vs 15.1%) and the disparity ratio is also lower than the national benchmark for this metric however, it indicates there continues to be a need for further action.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	11.3%	6.7%	1.68	Improvement
National Benchmark	15.1%	8.1%	1.86	

Performance for this indicator over time as displayed below has been mixed, with the 2021 data showing the worst position since WDES reporting was initiated. The disparity ratio has improved each year since then, however we still have a way to go before we are within the 0.80-1.25 range.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	11.3%	6.7%	1.68	Improvement
2023	11.7%	6.7%	1.75	Improvement
2022	13.2%	6.9%	1.91	Improvement
2021	14.7%	7.4%	1.98	Deterioration
2020	16.5%	9.8%	1.68	Improvement
2019	19.2%	11.3%	1.70	Deterioration
2018	20.4%	12.5%	1.63	-

METRIC 4C – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM COLLEAGUES IN THE LAST 12 MONTHS

The data displayed below focuses on colleagues who have reported experiencing harassment, bullying or abuse from other colleagues. The staff survey results and the disparity ratio show an adverse impact for disabled colleagues indicating a need for further action, although they are lower than the national benchmarks.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	23.9%	15.8%	1.51	Deterioration
National Benchmark	25.2%	16.2%	1.56	

Performance for this indicator over time as displayed below has been mixed. Over the last seven years progress has been made to improve the experience for disabled colleagues in relation to this metric, reducing the % of disabled colleagues reporting experiencing bullying, harassment or abuse from colleagues by 5.1%. yet it still remains an area where there is clear disparity between the experiences of disabled and non-disabled colleagues.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	23.9%	15.8%	1.51	Deterioration
2023	23.0%	16.0%	1.44	Improvement
2022	25.4%	16.2%	1.57	Improvement
2021	24.2%	14.0%	1.72	Deterioration
2020	26.7%	17.3%	1.54	Deterioration
2019	27.5%	18.5%	1.49	Improvement
2018	29.0%	18.1%	1.60	-

METRIC 4D – PERCENTAGE OF STAFF SAYING THAT THE LAST TIME THEY EXPERIENCED HARASSMENT, BULLYING OR ABUSE AT WORK, THEY OR A COLLEAGUE REPORTED IT

The data found that 51.9% of colleagues with a disability or LTC and 52.2% of colleagues without a disability or LTC reported occasions where they experienced harassment, bullying or abuse. The disparity ratio is almost 1.00 indicating, for this metric, colleagues are reporting a similar experience across the groups. The organisations scores are very similar to the national benchmarks.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	51.9%	52.2%	1.01	Improvement
National Benchmark	51.8%	51.7%	1.00	

Performance for this indicator over time as displayed below is fairly static, with the disparity range across the 7 years staying between 0.93 – 1.03.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	51.9%	52.2%	1.01	Improvement
2023	50.6%	52.0%	1.03	Improvement
2022	53.2%	51.7%	0.97	Deterioration
2021	46.6%	46.1%	0.99	Improvement
2020	49.4%	46.1%	0.93	Deterioration
2019	48.3%	47.2%	0.98	Deterioration
2018	46.5%	46.2%	0.99	No comparator

METRIC 5 – CAREER PROGRESSION AND PROMOTION

The data shows that 53.8% of colleagues with a disability and 58.8% of colleagues without a disability believe our organisation provides equal opportunity for career progression or promotion. The disparity ratio falls between 0.8 – 1.25 indicating for this metric there is no adverse impact for colleagues with a disability or LTC. The organisation's staff survey scores are slightly better than the national average; the disparity score is also slightly better than the national benchmark.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	53.8%	58.8%	1.09	Improvement
National Benchmark	51.3%	57.6%	1.12	

Performance for this indicator over time as displayed below remains fairly constant, without much movement in disparity ratio (range between 1.09 – 1.17) or the staff survey responses.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	53.8%	58.8%	1.09	Improvement
2023	53.9%	61.0%	1.13	Improvement
2022	52.4%	61.4%	1.17	Deterioration
2021	52.8%	60.0%	1.14	Deterioration
2020	55.4%	61.6%	1.11	Improvement
2019	53.8%	61.8%	1.15	Deterioration
2018	51.8%	58.1%	1.12	-

METRIC 6 – PRESSURE TO COME TO WORK WHEN NOT FEELING WELL ENOUGH

The data found that 22.7% of colleagues with a disability or LTC and 18.3% of colleagues without a disability or LTC felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The disparity ratio has improved from the previous year and now falls within the 0.80 – 1.25 range. It is the lowest it's been since WDES reporting began. The organisation's staff survey score for colleagues with a disability/LTC is better than the national average, the disparity ratio is also better than the national benchmark.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	22.7%	18.3%	1.24	Improvement
National Benchmark	26.9%	18.7%	1.44	

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	22.7%	18.3%	1.24	Improvement
2023	24.3%	16.0%	1.51	Deterioration
2022	26.1%	18.4%	1.42	Deterioration
2021	27.9%	21.7%	1.29	Improvement
2020	29.9%	21.9%	1.37	Deterioration
2019	29.4%	21.6%	1.36	Deterioration
2018	32.1%	24.0%	1.34	-

METRIC 7 – FEELING VALUED

There has been a drop in the overall percentage of colleagues reporting they are satisfied with the extent to which the organisation values their work; a more significant drop has been seen in the response rates for colleagues without a

disability/LTC (4.2%) than in colleagues with a disability/LTC (2.3%) which means, in spite of the drop in responses, the disparity ratio has improved. The disparity ratio falls outside of the 0.80 – 1.25 range at 1.34 indicating for this metric there is likely to be an adverse impact for colleagues with a disability, LTC or illness. The disparity ratio is also similar to the national benchmark.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	34.0%	45.6%	1.34	Improvement
National Benchmark	34.7%	47.0%	1.35	

Performance for this indicator over time as displayed below shows that the disparity ratios have improved over the last 2 years after a continuing decline.

Organisation Data Over Time

	Colleagues with a LTC or illness	Staff without a LTC or illness	Disparity Ratio	Change From Previous Year
2024	34.0%	45.6%	1.34	Improvement
2023	36.3%	49.8%	1.37	Improvement
2022	33.0%	48.4%	1.47	Deterioration
2021	35.8%	47.0%	1.31	Deterioration
2020	41.0%	51.4%	1.25	Deterioration
2019	39.5%	48.4%	1.23	Deterioration
2018	39.1%	47.0%	1.20	No comparator

METRIC 8 – ADEQUATE ADJUSTMENTS

This metric is concerned with the percentage of staff with a disability, LTC or illness who say the organisation has made adequate adjustments to enable them to carry out their work, 79.1% of colleagues with a disability, LTC or illness believed this has been their experience. The organisations score is significantly better than the national benchmark which is likely to reflect the work undertaken over the last few years to raise awareness around workplace adjustments and the Supporting Disability and Long-Term conditions agreement.

Organisation Data for 2024 and National Benchmark Comparator

	Colleagues with a disability, long term condition or illness	Change From Previous Year
Lancashire Teaching Hospitals	79.1%	Improvement
National Benchmark	74.0%	

Performance for this indicator over time has been mixed, typically with around 72.6%-80.8% of colleagues with a disability or LTC feeling adequate adjustments have been made to support them to carry out their work across this period. The last three years have shown a continued positive improvement in this metric.

Organisation Data Over Time

	Colleagues with a disability, long term condition or illness	Change From Previous Year
2024	79.1%	Improvement
2023	78.3%	Improvement
2022	75.1%	Improvement

2021	72.6%	Deterioration
2020	80.8%	Improvement
2019	74.7%	Improvement
2018	73.3%	-

METRIC 9 – ENGAGEMENT AND HAVING A VOICE

METRIC 9A – STAFF ENGAGEMENT SCORE

Colleagues with a disability/LTC had an engagement score of 6.2, those colleagues without a disability/LTC illness reported their level of engagement as 6.8. Both scores have fallen since the previous year, yet the disparity ratio remains the same at 1.09. Whilst disabled colleagues continue to report feeling less engaged than non-disabled staff, the disparity ratio remains within the 0.8 – 1.25 range indicating, for this metric, there is likely to be no adverse impact for colleagues with a LTC or illness. The organisation's staff survey result for disabled colleagues is worse than the national average, the disparity ratio is the same as the national benchmark as our staff survey result for non-disabled colleagues is also lower than the national average.

Organisation Data for 2024 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From Previous Year
Lancashire Teaching Hospitals	6.2	6.8	1.09	No change
National Benchmark	6.4	7.0	1.09	

Performance for this indicator has remained very stable over time.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2024	6.2	6.8	1.09	No change
2023	6.5	7.1	1.09	Deterioration
2022	6.4	7.0	0.92	Same
2021	6.4	7.0	0.92	Improvement
2020	6.7	7.1	0.94	Same
2019	6.6	7.0	0.94	Deterioration
2018	6.6	7.0	0.95	-

METRIC 9B – FACILITATING THE VOICES OF DISABLED STAFF TO BE HEARD

We have an active Living with Disability Ambassador Forum, along with number of awareness raising or support groups such as Menopause, Neurodiversity and Endometriosis, which all offer support for colleagues in addition to a forum where colleagues can discuss their lived experiences.

METRIC 10 – BOARD MEMBERSHIP

15.4% of the Board's voting membership identify as having a disability, this is approximately three times greater than the NHS average of 5.7%.

WDES ACTION PLAN

Nationally, NHS England have set six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The improvement plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although it is not limited to these groups) and links to the NHS People Plan. The six actions are as follows, all of which have been built into our strategic EDI action plan:

1) Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3) Develop and implement an improvement plan to eliminate pay gaps.
4) Develop and implement an improvement plan to address health inequalities within the workforce.
5) Implement a comprehensive induction, onboarding and development programme for internationally-recruited colleagues.
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Organisations are mandated to produce a detailed WDES action plan, elaborating on the priority areas identified in this report and setting out the next steps with milestones for expected progress against the WDES metrics. The actions to supporting improvements against WDES are incorporated within the Workforce and Organisational Development strategic action plan for equality, diversity and inclusion. The strategic action plan, alongside this WDES report will be co-designed with colleagues who participate in the organisations Living with Disability Inclusion Forum.

The strategic action plan will address the priority areas for improvement as found through the analysis of our data against the 10 WDES indicators alongside the views, ideas and actions valued by colleagues in the Disability Inclusion Forum. For clarity the strategic action plan for the next 12 months to support WDES improvements are:

- Continue to increase the declaration rates of disabilities and long-term conditions by colleagues and reduce the % of 'not known' against the disability field in our electronic staff record
- Improve the experience of disabled colleagues in respect of experiencing harassment, bullying or abuse from patients, relatives or other members of the public; managers and other colleagues
- Increase the percentage of disabled staff saying they are satisfied with the extent to which the organisation values their work.
- Continue to increase the percentage of colleagues who say the organisation has made adequate adjustments to enable them to carry out their work

Work has already commenced to support inclusive recruitment with a full review of the recruitment process being undertaken (in conjunction with the Head of Recruitment) to identify areas where there may be the potential for bias to occur and identifying mitigating actions. Over the last twelve months, we have seen a significant increase in the number of colleagues (and line managers) seeking support in respect of Neurodiversity; whilst we already have a Neurodiversity toolkit which colleagues can utilise, we are currently trying to understand what additional resources or support would be beneficial.

Some actions scheduled for progression over the next twelve months are to; understand more in respect of the staff survey results relating to harassment, bullying and abuse, review the Trust values ensuring that inclusive behaviours are made more explicit, design an Inclusive Language guide to support colleagues to have inclusive and psychologically safe conversations with colleagues which are free from fear around saying the 'wrong' thing, complete the work in relation to Inclusive Recruitment processes and practices, develop an Equality Representatives training module which supports colleagues in recruiting and managing formal workforce processes without bias. Design a talent management strategy that targets under-representation and lack of diversity at senior levels, specifically addressing issues around attracting and retaining younger talent as well as ensuring equity of career progression opportunities for staff of all protected characteristics, report on the number of colleagues who are indicating "Need one but do not have one" to the Supporting Disability & Long-Term conditions question within appraisal, and to quality assess the conversations which are taking place in respect of Supporting Disability and Long-Term condition agreements.

Agreed actions will form part of the wider action plan for the Equality, Diversity and Inclusion agenda under the Equality Strategy and the Our People Plan.

Next steps:

- To share this report with the Living with Disability Inclusion Forum to seek their views and lived experience in relation to these findings as well as to understand the actions they believe will help to reduce inequality and increase inclusion.
- To share the Workforce and Organisational Development strategic action plan for equality, diversity and inclusion with the Living with Disability forum and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.
- Submit results and action plan to the WDES team.
- Communicate results and action plan to our workforce through
    - Sharing results and actions with the Equality, Diversity and Inclusions Steering Group, for consideration as to how themes from the WDES report can support both corporate and divisional levels actions.
    - Sharing through Divisional Workforce Committee meetings.
    - Sharing further updates with the Disability Inclusion forum.
    - Managers Update Sessions.
    - Specific organisation wide communications in conjunction with the Communications team.
- Publish our results and action plan externally on the Trust website
- The strategic action plan will be implemented, with progress measured through the Equality Strategy Group and outcomes will be reviewed utilising the 2024 Staff Survey in conjunction with 2024 workforce data results.

FINANCIAL IMPLICATIONS

Research evidence indicates that, when organisations are more diverse and have a greater focus on inclusion colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all staff have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice. There are a number of risks which are impacting on our ability to deliver actions at pace against this agenda, this includes the lack of dedicated staffing resources to support the EDI agenda.

The size and scale of the programmes of work needed to deliver improvements for disabled colleagues is significant, especially when considered next to and needing to balance progress for colleagues with other protected characteristics. Combined with the level of understanding by the wider workforce with regards to their role in also delivering improvements for disabled colleagues, this work predominantly falls to the colleagues within Organisational Development – EDI team to drive forward transformation, increase awareness whilst supporting individual colleagues who have had negative experiences in their place of work.

IMPACT ON STAKEHOLDERS

Research evidence within the NHS tells us that the experiences of our colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Board of Directors:

- Receives and notes the report.
- Approve the report for publishing report externally.

The Workforce Disability Equality Standard 2025

Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The infographic below (for 2025) highlights the differences between the experience and treatment of Disabled colleagues and Non-Disabled colleagues, as an organisation we are committed to closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION

5.7% of colleagues have declared they have a disability or long-term health condition.

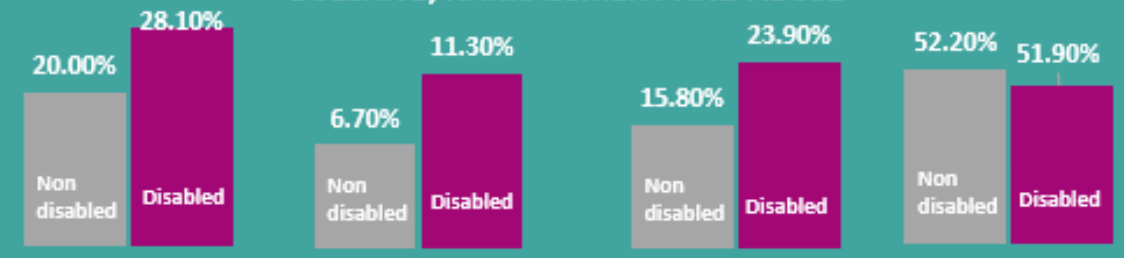
SHORTLISTING

Non-disabled colleagues are **1.06** times more likely to be appointed from shortlisting.

CAPABILITY PROCESS

Disabled colleagues are **1.98** times more likely to enter the formal capability process.

BULLYING, HARRASSMENT AND ABUSE



CAREER PROGRESSION

53.8%

of Disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion, compared with 61.0% of Non-Disabled colleagues.

PRESSURE TO WORK

22.7%

of disabled colleagues have felt pressure from their manager to come to work, despite not feeling well enough to perform duties., compared with 16.0% of Non-Disabled colleagues.

FEELING VALUED

34.0%

of Disabled colleagues are satisfied with the extent to which their organisation values their work, compared with 49.8% Non-Disabled Colleagues.

REASONABLE ADJUSTMENTS

79.1%

Of Disabled colleagues saying their employer has made adequate adjustments to enable them to carry out their work.

STAFF ENGAGEMENT SCORE

Disabled colleagues feel less engaged at work

6.2/10 Disabled

6.8/10 Non-disabled

BOARD MEMBERSHIP

3 Board Members (2 voting) identify with having a disability or long-term health condition out of a total of 17 Board Members

12.2 - RISK MANAGEMENT POLICY

REFERENCES

Only PDFs are attached

12.2 - Risk Management Policy - Board of Directors - June 2025 - Final.pdf

Board of Directors Report

Risk Management Policy

Report to:	Board of Directors	**Date:**	3 June 2025
Report of:	Associate Director of Risk & Assurance	**Prepared by:**	S. Regan
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The purpose of this paper is to present the reviewed Risk Management Policy for validation ahead of submission to the Procedural Documents Ratification Group (PDRG) in June 2025.

The Risk Management Policy was reviewed and presented to Risk Management Group in August 2024 in anticipation of being submitted to Audit Committee in September 2024 and the Board of Directors meeting in October 2024. However, the approval was paused due to anticipated changes to the Board Assurance Framework (BAF) and Trust meetings.

The policy has been further reviewed and updated, taking into account feedback from the initial consultation in August 2024, and March 2025, as well as some updates following Mersey Internal Audit Agency (MIAA) feedback in recent audits of Risk Management and the Board Assurance Framework. The policy was validated at Audit Committee in April 2025, and the final draft policy can be found in Appendix 1.

A summary of all changes can be found in the amendment section on pages 1 to 3 of the policy. Key updates at this review include:

- Amendments to reflect the Principal Risk framework and alignment to Strategic and Corporate Objectives, and the '5Ps' – Patients, Performance, People, Productivity, Partnership.
- Removal of the risk appetite and tolerance in line with MIAA recommendations. These are now maintained on the Intranet for colleagues to allow for more timely updates should mid-year changes happen.
- Inclusion of a section relating to the practical application of the Risk Appetite Statement and Risk Tolerances set by the Board, and reference to a strategic decision-making support tool to support staff in the use of appetite and tolerance when making decisions.
- Addition of Trust Management Board (TMB) in the Trust's governance structure.
- Amendment to reflect the name change of Confidential risks to Restricted Circulation Risks.
- Reference to the Single Improvement Plan.
- Confirmation that responsibility for overseeing Risk Management training compliance rests with Risk Management Group, in line with MIAA recommendations.
- The approval requirements for risks and the requirements for controlling risks.

It is recommended that the Board of Directors:

I. Review and validate the draft Risk Management Policy ahead of submission to the Procedural Documents Ratification Group (PDRG) in June 2025, for final approval.

Appendix 1 – Version 15.0 – Draft Risk Management Policy

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			
Risk Management Group – August 2024 Risk Management Group – March 2025 Audit Committee – April 2025			

1. Background

1.1 The purpose of this paper is to present the reviewed Risk Management Policy for validation ahead of submission to the Procedural Documents Ratification Group (PDRG) for final approval in June 2025.

2. Discussion

Risk Management Policy review 2025/2026

2.1 In pursuit of excellence in its risk management arrangements, the Trust aims to review the Risk Management Policy annually. A review was undertaken in August 2024 in keeping with this timescale in anticipation of being submitted to Audit Committee in September 2024 and the Board of Directors meeting in October 2024. However, a decision was made to pause the approval due to anticipated changes to the Board Assurance Framework (BAF) and Trust meetings.

2.2 The policy has been further reviewed and updated, taking into account feedback from the initial consultation in August 2024, and March 2025, as well as some updates following Mersey Internal Audit Agency (MIAA) feedback in recent audits of Risk Management and the Board Assurance Framework. The policy was validated at Audit Committee in April 2025, and the final draft policy can be found in Appendix 1.

2.3 A summary of all changes can be found in the amendment section on pages 1 to 3 of the policy. Key updates at this review include:

- Amendments to reflect the Principal Risk framework and alignment to Strategic and Corporate Objectives, and the '5Ps' – Patients, Performance, People, Productivity, Partnership.
- Removal of the risk appetite and tolerance in line with MIAA recommendations. These are now maintained on the Intranet for colleagues to allow for more timely updates should mid-year changes happen.
- Inclusion of a section relating to the practical application of the Risk Appetite Statement and Risk Tolerances set by the Board, and reference to a strategic decision-making support tool to support staff in the use of appetite and tolerance when making decisions.
- Addition of Trust Management Board (TMB) in the Trust's governance structure.
- Amendment to reflect the name change of Confidential risks to Restricted Circulation Risks.
- Reference to the Single Improvement Plan.
- Confirmation that responsibility for overseeing Risk Management training compliance rests with Risk Management Group, in line with MIAA recommendations.
- The approval requirements for risks and the requirements for controlling risks.

2.4 The draft policy has been considered alongside national documents from NHS Providers, NHS England and a review of policies for other NHS organisations and is considered to cover the national, regulatory and local requirements of the Trust.

3. Financial implications

3.1 There are no identified financial implications to amending the policy.

4. Legal implications

4.1 There are no identified legal implications to amending the policy.

5. Risks

5.1 The paper is risk focussed and introduces the updated Risk Management Policy with the intention to further improve governance and risk management within the organisation.

6. Impact on stakeholders

6.1 Positive risk management arrangements reduce the negative impact on patients and staff as its purpose is to mitigate and reduce, as far as is reasonably practical, the level of risk.

6.2 The Risk Management Policy has been updated following consultation with key stakeholders.

7. Recommendations

7.1 It is recommended that the Boad of Directors:

I. Review and validate the draft Risk Management Policy ahead of submission to the Procedural Documents Ratification Group (PDRG) in June 2025, for final approval.

DOCUMENT TYPE: Policy		**UNIQUE IDENTIFIER:** RMS-01	
DOCUMENT TITLE: Risk Management Policy		**VERSION NUMBER:** 15.0	
		STATUS: Draft	
SCOPE: Trust Wide		**CLASSIFICATION:** Organisational	
AUTHOR: Simon Regan	**JOB TITLE:** Associate Director of Risk and Assurance	**DIVISION:** Corporate Governance	**DEPARTMENT:** Risk Management
REPLACES: Risk management policy - 2023/24 version 14.0		**HEAD OF DEPARTMENT:** Simon Regan, Associate Director of Risk and Assurance	
VALIDATED BY: Audit Committee Board of Directors		**DATE:** 17 April 2025 Planned: 3 June 2025	
RATIFIED BY: Procedural Documents Ratification Group		**DATE:** Planned: June 2025	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** To be added by policy administrator	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
15.0	To be added (TBA)	Section 1 - Summary	Minor updates to wording.	TBA
15.0	TBA	Section 4.1.3	Updated to include the single improvement plan (SIP)	TBA
15.0	TBA	Throughout the document	Replaced Senior Leadership Team with Trust Management Board (TMB)	TBA

15.0	TBA	Throughout the document	Minor updates to wording to reflect the change from Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF)	TBA
15.0	TBA	Throughout the document	Updated to reflect the name change from Confidential Risks to Restricted Circulation Risks.	TBA
15.0	TBA	Throughout the document	Updated to reflect the Principal Risk framework and alignment to Strategic and Corporate Objectives, and the '5Ps' – Patients, Performance, People, Productivity, Partnership, and remove 'Our Big Plan'.	TBA
15.0	TBA	Throughout the document	Removed the current appetite and tolerance following MIAA recommendations,	TBA
15.0	TBA	4.2.6/4.2.9	Updated the Chief Finance Officer and Company Secretary roles to reflect that the Senior Information Risk Owner responsibility has changed. Also, the Company Secretary job title has changed to Director of Corporate Affairs.	TBA
15.0	TBA	4.7.3	New section added related to Applying the Risk Appetite Statement and Risk Tolerances set by the Board	TBA
15.0	TBA	4.8.3	Updated to reflect TMB and added a table with details of groups that oversee topical risk areas.	TBA
15.0	TBA	4.11	Updated to reflect approval requirements for risks.	TBA
15.0	TBA	4.12	Updated to reflect requirements for controlling risks.	TBA
15.0	TBA	4.16.7	Updated guidance for staff on other types of risk assessments and expanded the guidance on project risk assessments in the table.	TBA
15.0	TBA	4.17	Updated to include reference to the EQuality Impact Assessment (EQIA) process.	TBA

15.0	TBA	Appendix 1	Updated Committee Structure to reflect the addition of Trust Management Board (TMB). Also updated the feeder groups.	TBA
15.0	TBA	Appendix 2	Updated to reflect nomenclature, reporting and relevant leads	TBA
15.0	TBA	Appendix 3, section 6	Updated the guidance and examples relating to the description of the risk and the consequences of the risk occurring.	TBA
15.0	TBA	Appendix 3, section 4	Updated in relation to approvals	TBA
15.0	TBA	Appendix 3, section 6	Updated risk description guidance and the table examples.	TBA
15.0	TBA	Appendix 3, section 7	Updated title, guidance and examples in the table.	TBA
15.0	TBA	Appendix 3	Added a new section 10 related to risks outside of Division / Department / Trust's Control	TBA
15.0	TBA	Appendix 5	Updated to reflect the current fields in Datix	TBA
15.0	TBA	Appendix 6	Re-titled this section	TBA
15.0	TBA	Appendix 8	Re-named and minor updates and made it clearer to reflect that action plans should be uploaded as a document rather than adding actions to the action module in Datix.	TBA
15.0	TBA	Throughout the document	The policy has had a full review and includes some minor wording updates that are not itemised individually. The itemised updates above are included as they are considered necessary to highlight.	TBA

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: No
Evidence reviewed by Library Services: 07/04/2025 SR

CONTENTS

1. SUMMARY

Risk management is an integral part of Lancashire Teaching Hospitals NHS Foundation Trust's (LTHTR) management activity and is a fundamental pillar in embedding high quality, sustainable services for the people who access them.

As a large and complex organisation, delivering a range of services in a challenging operational and financial environment, the organisation accepts that risks are an inherent part of the day-to-day life of the Trust. Through a systematic approach to assessing, recording and managing risks the Trust fosters both a proactive and responsive culture in mitigating threats to its business, and in doing so, working towards the achievement of its strategic objectives.

The Trust understands that it must have in place robust and effective controls to mitigate the inherent risks involved in delivering healthcare. The Trust has in place a framework that allows the Trust to plan effectively to mitigate risks that may present themselves over time but that also enables the Trust to be agile in mitigating emergent risks that present themselves through the course of the Trusts' day-to-day operation.

In February 2024, the Board of Directors approved a Risk Management Strategy 2024-27 with the intention to use the strategy and the risk management processes outlined within this Policy as a means to achieve the highest levels of Risk Maturity within the Trust.

The Board of Directors are committed to ensuring that risks are managed appropriately in line with the Trust's Risk Management Strategy, this policy, the Trust's risk appetite and risk tolerances, and mandatory or best practice requirements.

By following this Risk Management Policy, the Trust aims to ensure a safe and secure environment for all stakeholders while meeting its legal and regulatory obligations, and continuously improving its services.

1.1 The Ideal Risk Management Framework

This relates to a working model in which:

- The organisation's management understand the risks to which it is exposed and deals with them in an informed, proactive manner.
- Required risk management practices are an accepted and natural part of the way in which the organisation operates.

This policy sets out in detail the framework the Trust has in place and the steps staff should take to identify, assess, record, and manage the risks that present themselves and in doing so working towards the delivery of strategic aims and objectives. In particular, the policy sets out the following:

- The Risk Management Process – How risks are identified, assessed, managed, controlled, reviewed and recorded at each level of the organisation (departmental, divisional, corporate and strategic).
- How the Board receives assurances that risks are being identified, managed, controlled, and reviewed effectively.
- Those in the Trust with key roles and responsibilities for co-ordinating and undertaking risk management activities.
- The role of the Board Assurance Framework (BAF).
- The role of Risk Registers.
- How Risks are monitored and escalated.
- The information mechanisms the Trust uses to identify risk patterns.
- How the Trust learns lessons from themes identified from risks.

2. PURPOSE

The Trust's Risk Management policy has been produced to assist all members of the organisation in understanding how the Trust manages risk, both strategically and operationally and serves as a practical guide to advise staff in the identification, management and reasonable control of the risks associated with providing healthcare at all levels of the Trust. Furthermore, the policy has been produced to outline how the Trust takes an integrated, whole-system approach to managing risks which is not separate to, or in addition to, the day-to-day management of the Trust.

The purpose of this policy is to provide a framework through which the Trust can:

- Ensure staff understand what risk and risk management is in the context of an NHS Foundation Trust.
- Ensure staff understand the purpose of the operational and principal risks, and their role in the context of the BAF.
- Embed a positive risk management culture throughout the Trust that supports and encourages employees to effectively manage risk.
- Ensure that there are effective and comprehensive risk management systems and processes in place to identify, assess, monitor and mitigate current and future risks, including cultural risks, and that these are continually reviewed, scrutinised and monitored.
- Ensure staff are aware of their duties in relation to risk management, with clearly defined roles and responsibilities for individuals within the organisation in relation to identification, management, review, approval and escalation of risks.
- Ensure staff are aware of, and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances, in order for the Trust to meet its corporate and strategic objectives.
- Ensure staff are aware of the systems and processes for the management of risk at local, divisional and organisational level along with the committee structures in place to support effective risk management throughout the Trust.
- Set out how to provide assurances that effective risk management is being undertaken at all levels of the Trust.

- Ensure staff understand how risks are to be escalated through the organisation.
- Describe to staff the information mechanisms the Trust uses to identify risk patterns.
- Describe how the Trust learns lessons from themes identified from risks.
- Ensure continued compliance with current and future standards and legislation.

3. SCOPE

This document applies to all employees of the Trust and is led by managers at all levels to ensure that risk management is a fundamental consideration of the Trust's approach to Safety, Quality, Workforce, Finance, Performance, Education, Research, and Corporate Governance.

4. POLICY

4.1 How the Trust sets its Objectives

The Trust have developed a new long term strategy in line with the requirements set out by the Department of Health, NHS England and the Trust's Regulatory Bodies (such as NHS Improvement and the Care Quality Commission).

As part of this, the Trust has developed a set of long term Strategic Objectives. These are supported by a set of annual Corporate Objectives which are linked to the strategic objectives of the Trust and will be refreshed on an annual cycle.

4.1.1 Strategic Objectives

The Trust's Strategic Objectives, referred to as the '5 Ps' are:

- **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*

These will be delivered through the Trust's Strategy, which is underpinned by Corporate Objectives.

4.1.2 Corporate Objectives

Each year the Trust will set annual corporate objectives which focus on delivering the strategy, whilst remaining agile to changes in policy and the operating environment.

4.1.3 Supporting Plans

Delivery of the Trust's Strategy is supported by a range of other detailed plans including the Always Safety First, Patient Experience and Involvement, Workforce and Organisational Development, Equality and Inclusion, Finance, Clinical Services,

Communications, Continuous Improvement, Digital and Health Informatic, Education and Training and Research and Innovation Strategies.

In addition, the Trust's Risk Management Strategy describes the Trust's approach to continually improve and mature our Risk Management arrangements from 2024-27.

In 2024, the Trust also developed a Single Improvement Plan (SIP) which brings together the Trust's priorities into one comprehensive plan.

4.2 Duties/Roles

4.2.1 Board of Directors

The Board of Directors is responsible for:

- Providing leadership and direction for effective risk management within the Trust.
- Reviewing the effectiveness of internal controls (its infrastructure) which includes; Safety, Quality, Workforce, Finance, Performance, Education, Research and Corporate Governance.
- Setting the Strategic Aims, Ambitions, Risk Appetite and Risk Tolerance.
- Taking a pro-active lead in the communication of risk management duties.
- Ensuring that an appropriate Trust Committee Structure is in place so that the Trust's Risk Management activity is subject to appropriate levels of oversight and scrutiny. A copy of the Trust's Committee structure is detailed in Appendix 1. These are supported by clear Terms of Reference.
- Overseeing and approving the BAF which comprises of the Principal Risks, and escalated Operational Risks at each meeting of the Board of Directors.
- Ensuring that Non-Executive Directors act as scrutinisers, ensuring that Risk Management is properly addressed and that the processes to support the Board of Directors in relation to risk, are robust.
- Informing and escalating risks of concern to the Integrated Care Board (ICB).

4.2.2 Chief Executive

The Chief Executive has overall responsibility and accountability for the Risk Management activity within the Trust and provides clear visible leadership, ensuring that the implementation of the Risk Management Policy and Risk Management Strategy is delegated appropriately to Executive Directors and through the Management structure of the Trust.

4.2.3 Chief Medical Officer

The Chief Medical Officer is the joint Executive lead (with the Chief Nursing Officer) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Chief Medical Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Clinical Risk is undertaken. The Chief Medical Officer is the responsible officer for medical staffing in

the organisation and is responsible for the professional leadership of Clinical Scientists, Pharmacists and Psychology. The Chief Medical Officer is the Trust's Caldicott Guardian and has responsibility for Medicines Safety and management, Mortality and Radiation. In addition to these responsibilities the Chief Medical Officer is responsible for the development and deployment of the Clinical Strategy.

4.2.4 Chief Nursing Officer

The Chief Nursing Officer is the joint Executive lead (with the Chief Medical Officer) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Chief Nursing Officer is also the Deputy Chief Executive, and works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of the Clinical Risk is undertaken. In addition, the Chief Nursing Officer has responsibility for the professional leadership of the Nursing, Midwifery & AHP workforce, Infection Prevention and Control, Safeguarding (adults and children), Patient Experience and Engagement, Maternity and Children's services alongside being the lead for clinical service regulatory inspections. The Chief Nursing Officer is also the Executive Lead for 'Well-Led' arrangements, Health and Safety and the accountable Director in ensuring that lessons are learned, shared, and communicated to staff when things go wrong. Alongside the Chief People Officer, the Chief Nursing Officer is the joint Executive lead for Equality, Diversity and Inclusion.

4.2.5 Chief Operating Officer

The Chief Operating Officer is the Executive lead for the management of risks to the Trust's operational activity and performance (performance risks). The Chief Operating Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Operational and Performance Risks are undertaken. In addition, the Chief Operating Officer is responsible for operational delivery of the Clinical Services, Emergency Preparedness, Resilience and Response (EPRR) and the management of the Divisional Improvement and Accountability processes.

4.2.6 Chief Finance Officer

The Chief Finance Officer is the Executive lead with overall accountability for the management of financial governance and risk and is also responsible for Capital and Estates. In addition to this, the Chief Finance Officer is the lead for 'Use of Resources' regulatory inspections.

4.2.7 Chief People Officer

The Chief People Officer is the Executive lead for the management of risks related to the Trust's workforce and education activity. The Chief People Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Workforce and Education Risks is undertaken. In addition to this, the Chief People Officer is responsible for Equality, Diversity and Inclusion alongside

the Chief Nursing Officer, Freedom to Speak Up arrangements, and Education regulatory inspections.

4.2.8 Non-Voting Members

There are a number of non-voting members of the Board who work closely with the Chief Executive and other Directors to ensure a whole systems approach to Strategy and Planning, Continuous Improvement and Transformation, Research, Informatics and Digital, Communication and Engagement, and lead on the management of risks in these areas.

4.2.9 Director of Corporate Affairs

The Director of Corporate Affairs is responsible for the overall corporate governance and legal arrangements that underpin effective risk management across the organisation, including ensuring the Trust is compliant with the NHS Code of Governance, which sets out best practice principles and processes to facilitate good governance, contribute to better organisational performance and provide safe, effective services for patients.

The Director of Corporate Affairs is also the Trust's Senior Information Risk Owner (SIRO) and is responsible for the management of Information Governance and Security and the associated risks.

4.2.10 Associate Director of Risk and Assurance

The Associate Director of Risk and Assurance is nominated as the Trust's 'Risk Champion' with overall responsibility for the management of the Risk Management Framework. The Associate Director of Risk and Assurance reports into the Chief Nursing Officer. Their role provides leadership for the implementation of the Trust's Risk Management Policy and the Risk Management Strategy, ensuring that the Trust consistently monitors and evaluates the effectiveness of its systems of internal control. The Associate Director of Risk and Assurance, supported by the Deputy Associate Director of Risk and Assurance works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of risk is undertaken.

They are responsible for providing professional leadership to Corporate and Divisional Operational Governance Leads and for ensuring regulatory standards are met, and are jointly responsible with the Associate Director of Safety and Learning for the oversight of delivery of Governance Key Performance Indicators.

4.2.11 Associate Director of Safety and Learning

The Associate Director of Safety and Learning is responsible for the delivery of the Risk Management Framework through the oversight and operational delivery of Safety and Learning, including Health and Safety. The Associate Director of Safety and Learning is jointly responsible with the Associate Director of Risk and Assurance for providing

professional leadership to Corporate and Divisional Operational Governance Leads, for the oversight of delivery of Governance Key Performance Indicators, and for ensuring regulatory standards are met. The Associate Director of Safety and Learning reports into the Chief Nursing Officer.

4.2.12 Deputy Associate Director of Risk and Assurance

The Deputy Associate Director of Risk and Assurance has responsibility for co-ordinating updates to the BAF, which involves liaising with the Executive Directors with lead responsibility to ensure the BAF reflects the principal risks to delivery of the Trust's Corporate Objectives, and the actions being taken by the Trust to mitigate such risks.

The Deputy Associate Director of Risk and Assurance is responsible for the management of the Head of Risk and Datix Systems, and in conjunction with the Associate Director of Risk and Assurance and Associate Director of Safety and Learning, leads on co-ordinating the implementation of the Trust's Risk Management Framework, Risk Management Policy, the Risk Management Strategy, and the operational activities that underpin them. They will achieve this by:

- Providing professional leadership to Corporate and Divisional Operational Governance Leads.
- Ensuring co-ordination and oversight for the Trust's Risk Registers.
- Supporting the Director of Corporate Affairs in enabling clear information flow and accountability at appropriate levels to maintain the BAF.
- Providing advisory support to the Trust's Divisional Management Teams and Divisional Governance Leads in the identification of Divisional Risks and the management of Divisional Risk Registers.
- Providing Quality Assurance guidance to Divisional Governance Leads.
- Ensuring oversight of the Trust's electronic Risk Management System.
- Ensuring oversight of information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk.
- Reviewing and monitoring regulatory standards relating to the management of risk.
- Ensuring the quality of risk management meets the required expectations.
- Ensuring a whole systems approach to the management of risk is undertaken.
- Ensuring capability building for all employees regarding risk management.

4.2.13 Head of Risk and Datix Systems, and Corporate Governance & Risk Team

The Corporate Governance & Risk Team provides operational support to the Head of Risk and Datix Systems and Deputy Associate Director of Risk and Assurance by:

- Supporting implementation of the Risk Management Policy and Risk Management Strategy within the organisation.
- Supporting Corporate and Divisional Management Teams, Risk Owners and Risk Handlers in maintaining and monitoring the quality of Risk Registers,

including ensuring appropriate identification and assessment of risk, the adequacy of risk descriptions, the adequacy of controls and assurances, action plans and justification of risk scoring.
- Maintaining and maturing the Trust's electronic Incident & Risk Management System.
- Producing information, reports and dashboards for Corporate and Divisional colleagues to assist with the management and monitoring of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk.
- Undertaking deep dives reviews of risks to support improved decision making.

4.2.14 Divisional Director for Estates, Facilities and Capital

The Divisional Director of Estates, Facilities and Capital is responsible for ensuring the safe maintenance of property and services in line with statutory estate compliance including pre-planned maintenance of the health and safety portfolio relating to security, violence and aggression, fire safety, environmental management, medical devices management, facilities provision and all aspects of estate and facilities business continuity.

The Divisional Director will:

- Support Managers and staff with the identification and management of estate related Health and Safety risks.
- Liaising with the Trust's Health and Safety Manager and Associate Director of Safety and Learning in the identification and management of estate Health and Safety risks.

4.2.15 Divisional Leadership Team - Divisional Directors, Divisional Medical Directors, Divisional Nursing, Midwifery &/or AHP Directors

All Divisional Leadership Team members have responsibility for the risk management activity in their Division, including:

- Providing leadership for Risk Management activities in their Division.
- Promoting and supporting the implementation of the Risk Management Policy and Risk Management Strategy.
- Monitoring and delivery of Governance and Risk key performance indicators contained within the Governance dashboard.
- Setting relevant and effective Divisional Objectives in support of delivering the Trust's Corporate and Strategic Objectives.
- Identifying operational risks which threaten the delivery of Divisional Objectives and establishing the Divisional Risk Register.
- Monitoring the Divisional Risk Register and escalating any divisional risks of concern scoring 15 and above to the Risk Management Group or Trust Management Board (TMB) meeting by exception (if required), should the Risk Management Group not hold a meeting.

- Monitoring the risk mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Quality assuring, monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Ensuring that Divisional Risk Management activity is owned; discussed and reviewed at the appropriate Divisional meetings (including Divisional Board, Safety and Quality, Workforce and Finance and Performance meetings).
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to Risk Management activities and are aware of their duties in relation to risk management identification, management, review and escalation of risks.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for Risk Management.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances.
- Presenting Risk Management reports to the Trust Risk Management Group (or TMB meeting by exception (if required) should the Risk Management Group not hold a meeting).
- Management of the identified risks within their Division/Department, including the escalation of risks, where appropriate.
- Promoting and embedding an 'open' and 'just' culture.
- Monitoring that all relevant risk assessments are undertaken, reviewed and documented appropriately.
- Ensuring lessons learnt from the management of risks are shared across the Division (as required).

4.2.16 Divisional Governance Lead and Team

All Divisional Governance Leads and their teams have responsibility to facilitate section 4.2.15 above and in addition to this, facilitate for the division:

- Identifying any operational risks that exist within the Division that threaten the achievement of Divisional, Corporate or Strategic Objectives.
- Providing support, advice and supplementary training (as necessary) in relation to Risk Management Activities in their Division.
- Promoting and supporting the implementation of the Risk Management Policy and Risk Management Strategy.
- Understanding and promoting awareness of the Trust's infrastructure for the management and mitigation of risk.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks, including use of the Datix System.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.

- Quality assuring, monitoring, and where appropriate, challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Undertaking Quality Assurance checks in accordance with guidance provided by the Associate Director of Risk and Assurance, and Associate Director of Safety and Learning.
- Promoting and embedding an 'open' and 'just' culture.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Divisional meetings.
- Undertaking Divisional administration on their Divisional Risk Register in Datix producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Supporting and ensuring Key Governance and Risk Performance Indicators are being delivered.
- Ensuring lessons learnt from the management of risks are shared across the Division.

4.2.17 Managers

Managers can include Associate Divisional Medical Directors, Clinical Directors, Clinical Business Unit Managers, Speciality Business Managers, Matrons, and Professional Leads (this list is not exhaustive). Managers at all levels have responsibility for supporting their Division / Department in the management of risks including:

- Identifying any operational risks that exist within the Specialty, Clinical Business Unit and/or Division that threaten the achievement of Divisional, Corporate or Strategic Objectives.
- Providing support, advice and training in relation to Risk Management activities in their Specialty, Clinical Business Unit and/or Division.
- Promoting and supporting the implementation of the Risk Management Policy and Risk Management Strategy.
- Understanding and promoting awareness of the Trust's infrastructure for the management and mitigation of risk.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks, including use of the Datix System.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances.
- Monitoring the Risk Mitigation activities within their Specialty, Clinical Business Unit and/or Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Quality assuring, monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Promoting and embedding an open and 'just' culture.
- Presenting Risk Management reports to Specialty, Clinical Business Unit and/or Divisional Meetings where required.

- Ensuring that Risk Management activity is discussed and reviewed at relevant Speciality and Divisional Governance Meetings.
- Supporting and ensuring key Governance and Risk Performance Indicators are being delivered.
- Ensuring lessons learnt from risks are shared within relevant departments.

4.2.18 All Ward, Department Managers and Clinicians have responsibility for supporting their Division in the management of their risks including:

- Identifying any operational risks that exist within the Ward/Department that threaten the achievement of Divisional, Corporate, and Strategic Objectives.
- To support the delivery of the Trust Risk Management Policy and Risk Management Strategy in accordance with their role.
- Understanding and promoting awareness of the Trust's infrastructure for the management and mitigation of risk.
- Monitoring activities within their Speciality, Service, Ward/Department to ensure compliance with all Trust Strategies and policies.
- Promoting and embedding an open and 'just' culture.
- Awareness of the Trust's infrastructure for the management and mitigation of risk.
- Monitoring activities within their Specialty, Service, Ward/Department to ensure risks are identified, assessed and entered onto the Trust Risk Register.
- Monitoring the Risk Mitigation activities within their Specialty, Service, Ward/Department Area to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Ensuring that Specialty, Service, Ward/Department Area of Risk Management Activity is discussed and reviewed at relevant meetings.
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to risk management activities, including use of the Datix System.
- Providing information to the Divisional Governance meetings on the identified risks within their Specialty, Service, Ward/Department.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for risk management.
- Informing the Divisional Management team of Risks that are being escalated to the Divisional Risk Register, where required.
- Supporting and ensuring key Governance and Risk Performance Indicators are being delivered.
- Ensuring lessons learnt from risks are shared within relevant specialities, wards and departments.

4.2.19 All Employees

All Employees have responsibility for supporting the management of the Trust's risks including:

- Reporting incidents and near misses using the Datix Incident Reporting System. The Trust accepts that the reporting of adverse events or near misses is on an 'open' and 'just' culture basis.
- Complying with the Trust Induction and Mandatory Training Programmes.
- Complying with the Trust Guidance and Instructions to protect the health, safety and welfare of anyone affected by the Trust's business.
- To support the delivery of the Trust Risk Management Policy and Risk Management Strategy, in accordance with their role.
- Awareness of the Trust's Risk Management systems and processes.
- Reporting identified risks to the relevant Senior Managers, Service, Ward/Departmental Managers and Clinicians to ensure risks are identified, assessed and entered onto the Trust Risk Register.
- Undertaking and completing any Risk Mitigation activities that are assigned to them.
- Ensuring that they obtain the necessary information, instruction, training and supervision in relation to risk management activities.
- Ensuring they are aware of risks within their work environment and of their personal responsibilities for risk management.
- Acceptance of personal responsibilities for maintaining a safe environment. Awareness of local emergency procedures, systems and processes.
- Provision of safe practice in their relevant specialty/role.
- Taking reasonable care of patients, their personal and colleagues' safety.
- Demonstrating a commitment to the Trust's Always Safety First agenda.

4.2.20 Staff Side Representatives

- To work in collaboration with Managers to promote risk management reporting by representing views and concerns, seeking to involve and ensuring fairness and equality.

4.3 Corporate Governance Committee Structure to Support the Risk Management Reporting Processes

The Trust will ensure that an appropriate Trust Committee Structure is in place to ensure that the Trust's Risk Management activity is subject to appropriate levels of oversight and scrutiny.

An organisational structure is in place, which supports the accountability arrangements within the Trust for Risk Management and ensures that all risks are properly considered and escalated to the Board as required. Through this structure, the Board of Directors ensures that adequate resources and support systems are in place to enable the Trust to effectively manage threats to its objectives.

The Corporate Committee Structure detailing the committees and groups which have responsibility for risk and facilitates the management and delegated responsibility for implementing risk management systems within the Trust is shown in Appendix 1. These are supported by clear Terms of Reference.

4.3.1 How the Board or High Level Risk Committees Review the Organisation Wide Risk Register

4.3.1.1 Board of Directors

The Board of Directors is responsible for ensuring the effectiveness of the Trust's infrastructure and has overarching responsibility for the Risk Management Strategy, and Framework.

The Board works actively to promote and demonstrate the values and behaviours which underpin the delivery of good governance and pro-active risk management, including being open and transparent.

The Board is accountable for all aspects of its business (i.e. safety, quality, workforce, finance, performance, education, research and corporate governance). The Board will systematically engage with patients, the public, staff and stakeholders on its objectives and plans, including hearing patient stories at Board meetings, undertaking patient safety walk rounds by members of the Board and wider communication events.

The Board is responsible for producing an Annual Governance Statement, which provides evidence of the robustness of the Trust's system of internal control. This is informed by the Head of Internal Audit Opinion and is subject to scrutiny by external auditors.

The Board has delegated aspects of the delivery of its functions to Board Committees and designated staff. These are described in Standing Orders and the Scheme of Reservation and Delegation. The Board, however, retains accountability and receives assurance on the delivery of its functions through the Board Committees and designated staff.

The Board of Directors is responsible for approving the addition or removal of risks to the BAF.

If the Board of Directors needs to be made aware of an emergent risk, the risk assessment may then be fast-tracked for consideration at Board or the appropriate Committee of the Board. In this scenario, the risk assessment must be approved by the Chief Executive (or nominated Deputy in their absence) and the Associate Director of Risk and Assurance (or nominated deputy in their absence), who will work with the Director of Corporate Affairs to facilitate inclusion on the Board of Directors or Committee of the Board agenda.

The Board of Directors is responsible for informing and escalating risks of concern to the Integrated Care Board (ICB) as required.

4.3.1.2 Risk Management Group

The Risk Management Group is the high level risk group which receives details of all high scoring operational risks (15 and above) for escalation from Divisional Boards

and the Corporate Operational Risk Register. It may also in the course of fulfilling its duties, receive details of other risks in the organisation, irrespective of the score. Each Division (and Departments within the Corporate Division) are scheduled to present their Risk Register according to the Cycle of Business on at least a quarterly basis.

The Risk Management Group is an operational group, not a Board Committee and provides the interface between the Board and the rest of the organisation. It has a key role in managing the assurance process; one of its key roles is monitoring risks that may meet the criteria for admission onto the BAF by rejecting those high scoring risks through effectively challenging the risk content and/or score or by accepting those high scoring risks which warrant further oversight through escalation to the relevant committees of the Board, for potential onward escalation to Board for admission onto the BAF. The Risk Management Group meeting also ensures there is a shared understanding and awareness of each of the Division's risks and allows the ability to escalate actions that are outside of a Division's control and/or create organisational or cross-divisional solutions.

Learning from the management of risk is expected to be shared as part of Division/Departmental updates at the group (where there is learning to share) and as part of thematic deep dives that are undertaken periodically by the Corporate Governance team.

The Trust Board must also ensure that any escalated operational risks that are on the BAF are reviewed bi-monthly. Risks recorded on the BAF that are well managed and have adequate controls may be de-escalated to the appropriate Operational Risk Register.

4.3.1.3 Trust Management Board

The Trust Management Board (TMB) is an operational group, not a Board Committee and provides the interface between the Board and the rest of the organisation.

The Risk Management Group is the primary group to oversee Risk Management within the organisation. However, in the event that there is a situation where the Risk Management Group does not hold a meeting in its normal cycle, the TMB can be used as a means to escalate any urgent risks that may warrant further escalation to Committees of the Board, or the Board of Directors meeting.

The TMB will consider business cases, which may include the risks associated with progressing/not progressing business cases. Any resultant risks may be included as an organisational risk and considered at the Risk Management Group also.

4.3.1.4 The Audit Committee

The Audit Committee is responsible for monitoring the effectiveness of the Trust's infrastructure and internal control system, including Risk Management and is responsible for providing assurance to the Board that this structure and these processes are appropriate and effective. This includes the formal approval of the

Trust's Annual Governance Statement. The lead Executive for Audit Committee is the Chief Finance Officer.

4.3.1.5 The Safety and Quality Committee

The Safety and Quality Committee is responsible for the following Risk Management Activities:

- Reviewing any Principal Risks and high scoring operational risks aligned to the Safety & Quality Committee at each meeting to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Safety & Quality Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.
- Review and accept or reject operational risks presented to the committee.
- Consider any further escalation to the Board of Directors where appropriate.
- Monitoring Principal Risks aligned to the Safety and Quality Committee.
- Provide assurance to the Board of Directors that Safety & Quality Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Safety & Quality Risks.
- The lead Executive for the Safety & Quality Committee is the Chief Nursing Officer.

Safety risk management is a fundamental component of the Trust's Always Safety First Strategy. Where a high operational safety risk is identified and spans across divisions, the mitigations and actions to reduce risk are overseen by the Risk Management Group. Always Safety First Learning and Improvement Group (ASFLIG) oversee patient safety improvement areas using clinical leadership, governance, data and continuous improvement methodology to drive actions and ownership, and reduce risk. Any concerns about potential risks can be escalated to the Patient Safety Incident Response Framework (PSIRF) Oversight panel, Risk Management Group, or Safety and Quality Committee who seek assurance that appropriate controls are in place as described above.

4.3.1.6 The Workforce Committee

The Workforce Committee is responsible for the following Risk Management Activities:

- Reviewing any Principal Risks and high scoring operational risks aligned to the Workforce Committee at each meeting to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Workforce Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.

- Receive assurance on the management of cultural risks and Restricted Circulation Risks from the Raising Concerns Group or the Divisional Improvement Forums.
- Review and accept or reject escalated operational risks. Consider any further escalation to the Board of Directors, where appropriate.
- Monitoring Principal Risks aligned to the Workforce Committee.
- Providing assurance to the Board of Directors that Workforce Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Workforce Risks.
- The lead Executive for Workforce Committee is the Chief People Officer.

4.3.1.7 The Finance and Performance Committee

The Finance and Performance Committee is responsible for the following Risk Management Activities:

- Reviewing any Principal Risks and high scoring operational risks aligned to the Finance and Performance Committee at each meeting to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Finance and Performance Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.
- Review and accept or reject escalated operational risks. Consider any further escalation to the Board of Directors where appropriate.
- Monitoring Principal Risks aligned to the Finance and Performance Committee.
- Providing assurance to the Board of Directors that Finance and Performance Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Finance and Performance Risks.
- The lead Executive for Finance and Performance Committee is the Chief Finance Officer.

4.3.1.8 The Education, Training and Research Committee

The Education, Training and Research Committee is responsible for the following risk management activities:

- Reviewing any Principal Risks and high scoring operational risks aligned to the Education, Training or Research Committee at each meeting to facilitate a Trust wide approach to mitigation.
- Identifying any deficiencies in the identification and management of Education, Training and Research Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.

- Review and accept or reject escalated operational risks. Consider any further escalation to the Board of Directors where appropriate.
- Monitoring Principal Risks aligned to the Education, Training and Research Committee.
- Providing assurance to the Board of Directors that Education, Training and Research risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Education, Training or Research risks.
- The Executive Lead for Education, Training and Research Committee is the Chief People Officer.

4.3.1.9 The Council of Governors

The Council of Governors (CoG) is responsible for the following risk management activities:

Collectively, governors play a key role in holding the Non-Executive Directors to account and to raise issues and concerns in a constructive manner. Their level of involvement and influence is a critical element to an effective risk management framework due to their experience and knowledge. This policy will continue to build the role of the CoG going forward as part of the assurance framework on quality governance and will enable reporting back to the CoG, any improvements made to service delivery. The CoG has a pivotal role in approving the Trust's Auditors and being a critical friend on patient experience via the CoG subgroups set up.

4.4 Risk Register Systems and Software

The Trust uses the Risk module of the DatixWeb System to identify and manage active risks and archive any controlled risks. This is a system that is well established and is in widespread use within the NHS and the wider Health Economy.

The Risk module serves as the Trust's Risk Register and contains the following:

- Principal Risk Registers.
- Corporate Department Risk Registers.
- Restricted Circulation Risk Register.
- Divisional Risk Registers.
- Specialty Risk Registers.
- Service/Ward/Departmental Risk Registers.

Details of what is contained in the Risk module is described in Section 4.8.4.

The Risk Register module is available to all staff across the Trust who have a user account on Datix. The full risk register (except Restricted Circulation risks) is accessible to allow cross Divisional or Departmental working on risk mitigation and to promote transparency of the Risk Register.

The benefit of using a single system is that it ensures a single source of the truth for Risk Register information, supports risks management standards to be maintained, and improves oversight of risk within the Trust.

Where a member of staff does not normally have access to a computer but has requested to 'view' the active Risk Register, this should be facilitated by their line manager or supervisor at the earliest opportunity.

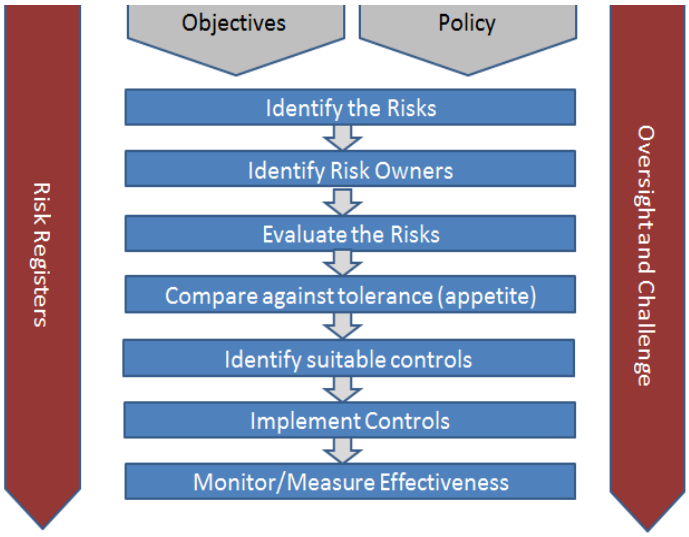
4.5 What is Risk and Risk Management?

A Risk: is an uncertain event or set of events which, should it occur, will have an effect upon the achievement of objectives. This consists of a combination of the level or scale of impact should the event occur, and the likelihood of the event occurring which can be evaluated via a risk assessment being undertaken.

A Risk Assessment: is the evaluation of an uncertain event that can interfere with the delivery of a Trust objective.

Risk Management: is in simple terms, the activity required to identify, assess and manage threats to achieving objectives. The Trust's Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its corporate and strategic objectives.

Figure 1 – Whole System Approach to Risk and Risk Management



In simple terms, Risk Management is the activity required to proactively and responsively identify, assess and manage threats to the achievement of objectives.

At a very top level, the Trust's Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its corporate and strategic objectives.

The Trust has in place a whole systems approach to Risk Management which is articulated in **Figure 1 above**; each of the steps in the Risk Management process is articulated in detail in Appendix 2 and 3.

4.6 Risk Management: Two Key Approaches

In undertaking Risk Management activity there are two key approaches that the Trust takes: the top down and the bottom-up approach.

Table 1: Describes the Trust's Top Down and Bottom Up approach to Risk Management

Top Down (Identifying Principal Risks)	The Trust manages its risks through Executive Management and Committee structures, which enables the identification, assessment and recording of Principal Risks. Principal Risks are risks which threaten the achievement of the Trust's Corporate and Strategic Objectives, and form part of the Board Assurance Framework (BAF). The management of Principal risks also consider the implementation and monitoring of controls and mitigating actions. (Principal Risks may also be identified through the monitoring and reporting of Operational risks).
Bottom Up (Identifying Operational Risks)	The Trust undertakes operational Risk Management activity through staff working in adherence to the Trust's Risk Management Policy. Operational Risks may present themselves via incidents, complaints, claims, patient feedback, safety inspections, external review, ad hoc assessments etc., which may impact on the Trusts ability to meet its objectives and targets.

Figure 2 – Risk Management Activity – Top down and Bottom up approach

Principal Risks to the delivery of the Trust's Corporate Objectives

4.7 Risk Appetite Statement and Risk Tolerances

The Trust recognises that:

- it is operating in a collaborative healthcare economy where patient safety, quality of service and organisational viability is vitally important.
- there is always a level of inherent risk in the provision of acute healthcare which must be accepted or tolerated, but which must also be actively and robustly monitored, controlled and scrutinised.
- it has finite resources in terms of staff, equipment and finances available to it in the delivery of healthcare services.

4.7.1 Risk Appetite Statement

In response to the above factors the Trust will seek to manage risks in accordance with a Risk Appetite Statement. Each risk will be aligned to a Strategic Objective and the appetite should be considered in line with the Boards agreed Risk Appetite Statement relevant to the Strategic Objective. The Board of Directors reviews its Risk Appetite at least once every financial year and the current version of the Risk Appetite Statement can be found on the Risk Management and Maturity Intranet page.

Risk Appetite: is the decision about the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

4.7.2 Risk Tolerance

All identified risks will be required to have a target score which is the level of risk that may be tolerated in order to consider a risk reasonably controlled. Each risk will be aligned to a Strategic Objective and the target score should be considered in line with the Boards agreed Risk Tolerance relevant to the Strategic Objective. The Board of Directors reviews its Risk Tolerance at least once every financial year and current version can be found on the Risk Management and Maturity Intranet page.

Risk Tolerance: is the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives in accordance with the Trust's Strategy and Risk Appetite.

4.7.3 Applying the Risk Appetite Statement and Risk Tolerances set by the Board

Understanding and applying risk appetite and tolerance is essential for effective risk management and strategic alignment. By integrating these concepts into daily operations, staff can make informed decisions that support achieving the Trust's aims & ambitions while managing risks within acceptable levels. Regular training, open communication, and continuous improvement are key to embedding these practices into organisational culture.

The Risk Appetite Statement and Risk Tolerances are reviewed and set by the Board of Directors at least once each financial year, and should be used as a guide to support:

- **Decision-Making:** Use risk appetite as a guide when making decisions. If a potential decision involves taking risks inconsistent with the Trust's appetite, consider alternatives or mitigation strategies.
- **Risk Assessment:** When assessing risks, compare them against the risk tolerance levels. This helps determine whether additional controls or mitigations are needed to mitigate the risk in line with the expectations set by the Trust.
- **Monitoring and Reporting:** Regularly monitor risk levels and report on their status. Ensure that any risks breaching tolerance levels are addressed as quickly as possible.

To help and support the use of Risk Appetite and Tolerance when making decisions, a Strategic Decision Making Support tool has been developed and the most up to date version can be found on the Risk Management and Maturity Intranet page.

4.8 Risk Management Framework (including Board Assurance Framework, Principal Risk Registers and Operational Risk Registers)

4.8.1 The Board Assurance Framework

The **Board Assurance Framework** (BAF) provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's corporate and strategic objectives, and is made up of two parts the **Principal Risk Register** and the **Operational Risk Register**.

- **Principal Risks** are 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 Trust's overall strategic objectives.
- **Operational Risks** are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. They mainly affect internal functioning and delivery and are managed at the appropriate level within the organisation.

The BAF records organisation wide Principal Risks, which includes risks identified in relation to delivery of the Trust's Corporate Objectives. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every Principal 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.

4.8.2 Trust Wide Principal Risks

As part of the Annual Planning process, the Trust will establish its Strategic and Corporate Objectives. The Board of Directors will continuously monitor progress with delivery of the Corporate Objectives and identify any organisation wide principal risks that may threaten the achievement of the Trust's Strategic and Corporate Objectives. The Board will then establish what the Principal Risks are and identify and review the controls and systems in place to mitigate these risks.

Each Principal Risk is aligned to a Committee of the Board where updates and progress is presented at each meeting for scrutiny, which in turn feeds into the BAF. Each Principal Risk is reviewed and revised in advance of sub-committees of the Board by Executive Directors.

Through the BAF, the Trust will document all its Principal Risks, the key controls that are in place to manage and mitigate them, and which Executive Director is leading on the mitigation. The Principal Risks are monitored as part of the BAF at every Board of Directors meeting, where the Trust's Executive and Non-Executive Directors review and are able to challenge the levels of assurance offered. Should a gap be identified in the control, management and mitigation of the risk, the gap will be managed appropriately by the Executive lead.

The Board will undertake the final validation of any new Principal Risk assessments and agree inclusion of new risks onto the Board Assurance Framework.

Updates to Board are supplemented by a summary dashboard which details the Principal Risks alongside initial, target and current scores to provide a visual overview of the direction of change in score over time.

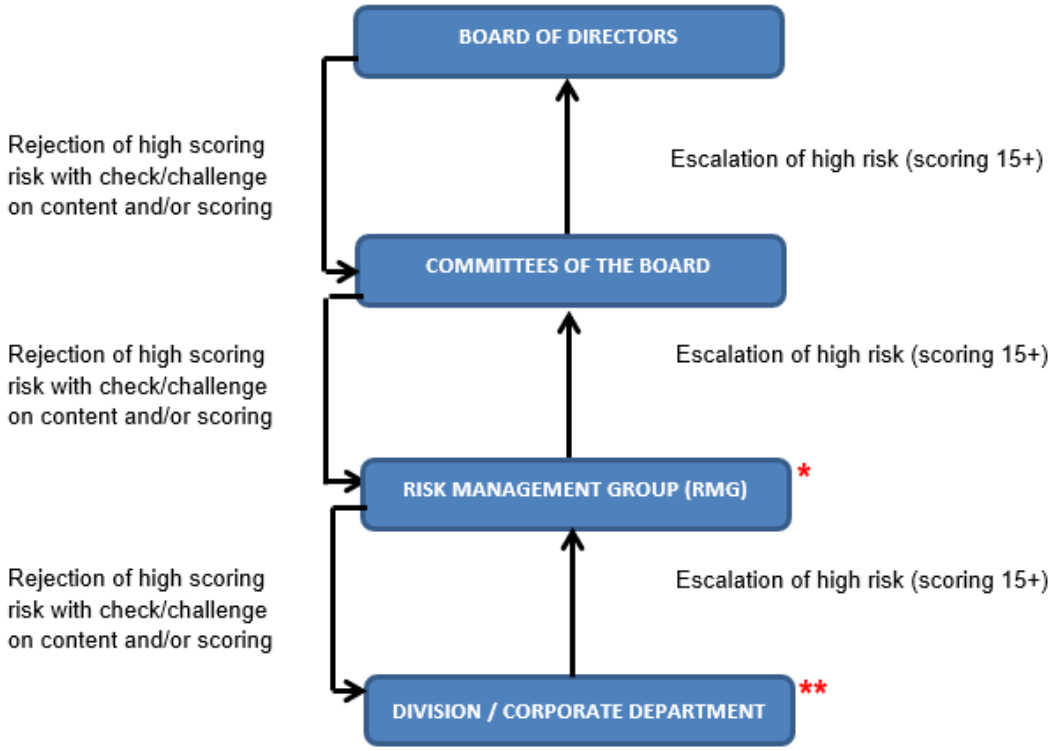
4.8.3 Operational Risks and the Trust Risk Register System

To provide oversight and scrutiny of the Operational Risk Management Activity, Risk Registers are available at a Corporate, Divisional, Specialty and Ward/Departmental level. To ensure oversight of this, Governance and Risk dashboards are in place that are included in Divisional Improvement Forums and reviewed at each meeting of the Risk Management Group.

All operational risks are aligned to the strategic objectives, and in turn aligned to Committees of the Board.

Any operational risks that have been rated as 'High' (Risk Score of 15 to 25) are maintained on Divisional Risk Registers and provided alongside any high scoring Corporate operational risks to the Risk Management Group meeting, and subsequently to Committees of the Board, who can decide whether to escalate operational high risks of concern to the Board of Directors, as shown in Figure 3.

Figure 3 – Escalation of High (15-25) Operational Risks



* In the absence of the Risk Management Group meeting, urgent risk escalations can be made via the Trust Management Board (TMB) meeting to Committees of the Board.

** This could include escalation from Divisional Board, Divisional Safety and Quality Committee, Divisional Finance and Performance Committee, Divisional Workforce Committee or Corporate Departments.

The Board of Directors are responsible for informing and escalating risks of concern to the Integrated Care Board (ICB) if required.

Having a formal process in place allows for check and challenge of the information for accuracy to support appropriate recommendations for escalation to Board as part of the BAF. All risks are scored in line with the National Patient Safety Agency (NPSA) scoring matrix found in Appendix 7.

The Trust has functional groups and committees that oversee specific areas of risk including:

Group/Committee	Oversees risks relating to
• Emergency Preparedness, Resilience and Response (EPRR) Committee	• Emergency Preparedness, Resilience and Response • Business Continuity plans
• Information Governance and Records Committee	• Information Governance and Security • Data Protection and confidentiality

Group/Committee	Oversees risks relating to
• Senior Information Risk Owner/Asset Information Owner Working Group	• Records Management • Asset Management
• Infection Prevention and Control Group	• Infection Prevention and Control • Healthcare associated infections • Antimicrobial resistance • Infection outbreaks • Isolation Procedures • Environmental cleanliness • Surveillance of infections
• Safeguarding Board	• Safeguarding vulnerable adults • Child protection • Domestic abuse • Mental Capacity and Deprivation of Liberty Safeguards • Allegations against staff
• Medicines Governance Committee	• Medication safety • Controlled Drugs • Adverse drug reactions • Antimicrobial stewardship • High Risk Medicines • Medical Gases
• Health and Safety Governance	• Compliance with Health and Safety legislation • Fire • Security • Water safety • Electrical safety • Asbestos • Control of Substances Hazardous to Health (COSHH) • Workplace safety risks (such as lone workers, display screen equipment (DSE), slips, trips and falls • Medical devices • Radiation safety • Violence and aggression
• Raising Concerns Group	• Culture risks
• Training Compliance and Assurance Committee	• Risks to non-delivery of required training

Through reviewing and monitoring Operational Risk Registers through its Board, Committee, Divisional, Specialty, Ward/Departmental structures, and with functional groups overseeing key risk areas, the Trust can gain assurance as to the appropriateness and effectiveness of Risk Management activity at all levels of the Trust.

4.8.4 Risk Register Format

The Risk Registers are recorded into the Datix System using a standard template and the severity of each risk is rated according to the consequence/likelihood Risk Assessment Matrix from the National Patient Safety Agency. The Data fields included in the standard template are detailed in Appendix 5.

The operational risk registers identify and record the following:

- The Location of the Risk (Site, Division, Specialty and Department).
- The Risk Handler and Risk Owner.
- The date the Risk was identified.
- The description of the Risk.
- The source of the Risk.
- The strategic and corporate objective the risk impacts upon.
- The Committee of the Board that the risk is aligned to.
- The controls that are in place to assist in securing delivery of the objectives.
- The assurances that enable evidence to be gained that controls are effective.
- The current risk rating - the risk rating with the current controls in place.
- The actions that are being taken to improve the level of control and assurance in order to mitigate or reduce the risk.
- The target risk rating - the desired risk rating with the mitigating actions completed, which should be considered in line with the Trust Risk Appetite Statement and Risk Tolerance.
- The date of next review.
- The review history.
- Any supporting documents or evidence attached to the Risk.

These in turn facilitate the ability to produce risk reports and dashboards.

4.9 Operational Risk Levels, Management, Monitoring and Escalation

As a 'Clinically Led Organisation' the Trust believes that operational risks are best managed by the Clinicians and Managers that are closest to be able to support the right actions to the mitigate the risk. Clinicians and Managers should also receive appropriate and robust guidance, support and oversight from Divisional, Corporate and Trust Management teams, Assurance Committees and functional experts.

The frequency at which a Risk should be reviewed is determined by the risk score with higher scoring risks requiring more frequent review. Any risk rated as 'High' (15-25) must be reviewed monthly and any risk rated as 'Significant' (risk score 8-12) must be reviewed on at least a quarterly basis. Risk Review frequency guidance is included in Appendix 4.

The robust and overlapping monitoring and escalation processes will ensure that risks are not managed by Clinicians or Managers without sufficient authority, experience and knowledge to mitigate the risk and that risks are identified and escalated as quickly

as possible. Table 4 contains guidance as to the recommended approach – note that there may be some slight differences based on job titles and the nuanced governance structures of some specialities and departments.

Table 4: Overview of Risk Levels, Management, Monitoring and Escalation

Risk Level	Impact/ Management	Monitoring	Escalation
Service/ Ward/ Department	Impacts on a single ward/department on a site. Managed by a Ward/ Department Lead Clinician or Manager	Ward/Departmental Governance Meetings.	Speciality Governance Meetings. Clinical Business Unit Governance Meetings. Divisional Governance Meetings. Risk Management Group and Trust Management Board (as appropriate).
Speciality	Impacts on multiple wards/departments or sites within a speciality. Managed by a Speciality Lead Clinician or Manager	Speciality Governance Meetings. Clinical Business Unit Governance Meetings. Divisional Governance Meetings.	Clinical Business Unit Governance Meetings. Divisional Governance Meetings. Risk Management Group and Trust Management Board (as appropriate).
Divisional	Impacts on multiple specialities within a division. Normally managed by a member of the Divisional Triumvirate / Quadrumvirate	Specialty Governance Meetings. Clinical Business Unit Governance Meetings Divisional Governance Meetings.	Divisional Improvement Forums (DIFs), Risk Management Group, Trust Management Board (as appropriate).
Trustwide	Impacts on multiple Divisions or all Divisions. Managed by relevant Lead	Specialty Governance Meetings. Clinical Business Unit Governance	Divisional Improvement Forums (DIFs), Risk Management Group, Trust

Risk Level	Impact/ Management	Monitoring	Escalation
	Clinician or Manager	Meetings Divisional Governance Meetings, Risk Management Group, Trust Management Board (as appropriate).	Management Board (as appropriate), Associate Director of Risk and Assurance / Associate Director of Safety and Learning, Committees of the Board, Board of Directors.

4.10 The Risk Management Process

The Risk Management process is the activity required to identify, assess and manage risks in order to achieve its objectives. Risk Assessment and Management Guidance, and Flow Chart are included in Appendix 3 and 4.

4.11 How Operational Risks are added to the Trust Risk Register

All Trust staff with a Datix user account can add a new risk to the Datix system. There are specified mandatory data items that must be completed before a new risk can be saved; this is to ensure that minimum data requirements are achieved. Staff who do not have a password for the Datix system should speak to their Ward/Department Manager to raise risk matters. The Ward/Department Manager has a responsibility to respond to any risk identified to them.

All newly created divisional risks are held in a 'Pending Tray' to allow for a Quality Assurance check by Divisional/Corporate leaders/Governance teams. The purpose of the 'pending Tray' is to prevent the inadvertent addition of duplicate existing risks and to ensure that risk assessments have been completed to the standard required by this Policy.

The decision to approve or decline a Risk from the 'Pending Tray' will be taken by Division/Speciality leads in conjunction with Divisional/Corporate Governance leads. This will usually be undertaken as part of a governance meeting. However, approval of risks should not be unduly delayed whilst waiting for meetings to occur as to do so may prevent timely escalation of the risk. Where a risk is identified as scoring 15 or above at the time of the initial assessment to add this to the risk register, this should be approved in consultation with the relevant member of the Divisional Management Team, or Corporate lead, and the relevant Divisional / Corporate governance lead.

Once approved, the risk should be marked as an 'Active risk' by selecting this in the 'Approval status after save' drop-down menu on Datix, and adding the date of approval

where indicated. This will add the risk to the risk register and ensure that the risk is included in risk register reports.

4.12 Controlling Risks on the Trust Risk Register

Risk registers need to be current and up to date. It is therefore essential that risks are continually monitored and fully reviewed in line with the review schedule at Appendix 4.

When a Risk Handler or Owner believes that a risk has been suitably mitigated and can now be considered reasonably controlled, they can identify the risk as 'controlled' through selecting this in Datix with rationale. 'Controlled' is to be used where:

- The Risk has reached its target score and has remained stable for an acceptable period of time (following appropriate authorisation)
- The Risk has reached its tolerance level (see more information about Board defined tolerance / appetite in sections 4.7.1 – 4.7.3 of this policy and on the Risk Management and Maturity Intranet page) and further treatment is considered disproportionate to the potential benefits.

Any risks that are controlled, should include details of the division/department approval in the dedicated section for documentation of Divisional/Departmental approval to control on the risk record on Datix when the record is placed into the "Controlled Risks" approval status.

Risks that are rated as High would not normally be eligible for control if the inherent risk remains. However, should there be considered to be a legitimate reason to do this, it would need discussion with the Associate, or Deputy Associate Director of Risk and Assurance to ensure the right approvals are sought, and through the appropriate governance route.

All controlled risks will be archived and not deleted on Datix.

4.13 Risk Management Training

The Trust has a refreshed Training Needs Analysis (TNA) which outlines the Risk Management training required. The training will be reviewed on an ongoing basis to consider strengthening the training around risk management topics.

As Risk Management training is part of an essential training requirement, training figures will be produced by the workforce team and reported in line with other mandatory and essential training.

The Risk Management Group will receive updates on compliance with Risk Management training.

4.14 Risk Reports

The following types of standardised Risk reports will be produced at Board of Directors Level:

- Board Assurance Framework detailing the Principal, and escalated operational risks that may compromise the achievement of the Trust's Objectives.

The following types of standardised Risk reports will be produced at Committee Level:

Summary Position and exceptions which will include, but is not limited to:

- Changes in High Risk Ratings.
- Content of Principal Risks.
- Details of operational high risks aligned to the relevant objective monitored by the Committee.

The following types of Risk reports will be produced at Division / Corporate Department Level:

- Changes in Risk Ratings.
- Risk Performance Key Performance Indicators.
- Risks that have been controlled.
- Risks overdue for review.
- Risks that have 'No controls in place'.
- Risks with 'No open actions in place'.
- Open mitigating actions that are overdue.
- Themes and Profiles.
- Risk Register report.

There may be some variations to the above between the different Divisions / Corporate Departments.

An individual risk report template is detailed in Appendix 6 should this be needed to review an individual risk at a meeting. This can also be generated from the Datix system.

4.15 Reporting on the Triangulation of Risk Information and Risk Themes

The Trust seeks to triangulate information, especially thematic profiles and trend analysis, with similar information that is produced in respect of Complaints, Incident Management, Audit, Mandatory Training, National Institute for Health and Care Excellence (NICE) Guideline compliance.

The purpose of this is to act as an 'Early Warning System' to enable the early identification of potential problems so that early action can be taken to reduce or remove these problems.

Key Performance Indicators related to Governance and Risk Maturity are included within the Governance Dashboard which is presented at Divisional Meetings, Divisional Improvement Forums and the Risk Management Group. Relevant indicators are also included in the Integrated Performance Report to Safety and Quality Committee, and Board.

4.16 Assurance (including Internal and External Audit)

The Trust Board via the Audit Committee will receive assurances on the effectiveness of the risk management framework annually by receiving the Head of Internal Audit Opinion following the Internal Audit reviews undertaken throughout the year and reported to the Audit Committee.

4.16.1 Benefits of an Assurance System

An assurance system achieves a number of benefits:

- Provides confidence in the operational working of the Trust.
- Maximises the use of resources available in terms of audit planning, avoiding duplication of effort.
- Ensures assurances are appropriately gathered, reported and that the governance structure is working as intended.
- Identifies any potential gaps in assurances relating to key risks and key controls, and that these are understood and accepted or addressed, as necessary.
- Supports the preparation of the Annual Governance Statement and regular assurance reports.

4.16.2 Types, Sources and Levels of Assurance

There are three types of assurance, which are referred to as the three lines of defence:

Level 1 - Departmental Assurance

- Local Management Oversight – direct management assurances.

Level 2 - Corporate Assurance

- Corporate Oversight – internal assurance sources (including assurance committees), independent from direct management assurance sources.

Level 3 - Independent Assurance

- Independent Oversight – External Auditors, Internal Auditors, Regulators, External Benchmarking etc.

4.16.3 Assurance Values

Independent assurance is used to confirm management assertions and is often seen as of highest value. This is however dependent on many other factors as noted below including:

- Age – the time elapsed since assurance was obtained, this may erode the value of assurance.
- Durability – whether it endures as a permanent assurance on an historical matter e.g., Auditors Report on Financial Statements, or loses relevance over passage of time e.g. clinical audit.
- Relevance – the degree to which assurances align to specific areas or objectives over which it is required.
- Reliability – trustworthiness of the source of assurance.
- Independence – the degree of separation between the function over which assurance is sought and the provider of assurance.

4.16.4 Independent External Assurance

The Board receives independent assurance(s) that a Risk Management System is in place that meets with the requirements of the Risk Management Standards through the process of internal and external audit and from external assessments, reviews and benchmarking, for example:

- Care Quality Commission visits/inspections.
- National Audits.
- Reviews of external independent reports.
- Integrated Care Board (ICB) Quality Monitoring.
- Health and Safety Inspections.
- OFSTED (Office for Standards in Education) inspection.
- Other Regulatory Inspections.
- External Audit Reports.
- Internal Audit reports from externally appointed 3rd party.
- Royal College reviews.
- Annual Head of Internal Audit Opinion.
- National Staff Surveys.
- NHS Resolution Reports.
- National Patient Satisfaction Surveys.
- Patient Led Assessments of the Care Environment (PLACE) Inspections

4.16.5 Internal Assurance

The Trust will seek assurance that risks are being appropriately identified and managed through the following:

- Trust Board Integrated Performance Report.
- Single Improvement Plan (SIP).
- Divisional Improvement Forums (DIFs).

- Performance Reviews.
- Key Performance Indicators including internal standards.
- Minutes.
- Committee Reports.
- Divisional Management Board Reports.
- Annual Quality Accounts.
- Clinical audits.
- Development and review of Risk Registers.
- Board Assurance Framework.
- The Annual Governance Statement.
- Benchmarking activity.
- Compliance with mandatory induction and training standards.
- Response to Medical Devices Alert (MDA)/National Patient Safety Agency (NPSA)/Estates and Facilities (EFA) alerts and hazard notices.
- Incident investigations.
- Incident, claims and complaints trends.
- Patient and staff surveys.
- Corporate Quality Reviews.
- Patient Safety/Quality Walkabouts.
- Safety Triangulation Accreditation Review (STAR) aims to ensure that suitable evidence exists to support adherence with regulatory and accreditation standards. The STAR team provides support for such reviews.

4.16.6 Key Stakeholders Assurance

In addition to the internal routes for raising concerns and risk, there are formal mechanisms by which our key stakeholders can raise risk concerns.

These include:

- Regular contract and performance review meetings.
- Patient Safety Incident Response Framework (PSIRF) process.
- Complaints process.
- Claims process.
- Regulators.

4.16.7 Other Risk Assessments

A wide variety of ‘Risk Assessments’ are systematically identified and reported throughout the Trust. In most cases it is not appropriate that these ‘Risk Assessments’ are entered into the Trust Risk Register as ‘Active Risks’ as they are often task / person specific risk assessments in relation to compliance with statutory responsibilities under Health and Safety legislation, or related to individual patients as part of their care journey.

Detailed below are some of the most common of these ‘Risks Assessments’. Where these assessments may indicate a wider ongoing risk that requires mitigation, consideration should be given as to whether these should be added to the risk register.

Guidance is available from the Corporate Governance Team should any support be required.

Patient Risk Assessments	A wide variety of Patient-related Risk Assessments may take place including; Bed Rails, Falls, Hydration, Nutrition and Tissue Viability etc. These risk assessments associated with the patient's clinical circumstances and should be recorded within the Patient's individual record.
Incident Reporting	Specific detail regarding the Incident risk assessment process can be found in the Trust's 'Adverse Incident Reporting, Management and Investigation Policy and Procedure.'
Complaints	Specific detail regarding the Complaints risk assessment processes can be found in the Trust's Complaints Policy and Procedure.
Litigation .	Specific detail regarding the Litigation risk assessment processes can be found in the Trust's 'Policy and Procedure for handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses'.
Workplace, Environment, Health and Safety and Security Assessments	Specific detail regarding the Workplace, Environment, Health and Safety and Security risk assessment processes can be found in the Trust's 'Health and Safety Policy'.
Clinical Audit	Specific detail regarding the Clinical Audit risk assessment processes can be found in the Trusts' Clinical Audit Policy and Procedure. Clinical Audit is a key component of the assurance framework, as such, regular clinical audit performance activity reports as presented to the Audit Committee for oversight and coordination with the Internal Audit plan. Dependent on the extent of non-compliance it may be appropriate to record a risk on the risk register. This would need to be assessed by the relevant clinician or manager.
NICE Guidance and Standards	Specific detail regarding the National Institute of Health and Care Excellence (NICE) publications and Quality Standards risk assessment processes can be found in the Trusts' Implementation of NICE publications and Quality Standards Procedure. Dependent on the extent of non-compliance it may be appropriate to record a risk on the risk register. This would need to be assessed by the relevant clinician or manager.
Project Risk Assessments	Specific detail regarding the risk assessment processes for project risks can be found in the project documentation and are managed as risks to the delivery of a project in line with project management principles. Where there is a significant risk to the overall progress or delivery of a

	project, it may be appropriate to record the overall risk of not completing this a risk on the risk register. This would need to be assessed by the relevant person.
Internal and External Reviews/Reports	Risks that are identified from internal and external audit reports and other reviews, assessments and accreditation, would need to be carefully assessed by the relevant Clinician or Manager to ascertain if a risk exists and needs to be placed on to the Trust's Risk Register.

4.17 Risk Management link to Business Planning and Programme Management

As part of the Trust's annual business planning cycle, key risks alongside material business cases will be considered to ensure business and operational plans reflect the issues and risks that are most critical to the success of the organisation. This process will consider a range of factors including integrated financial and non-financial information along with any key safety and quality priorities. In order to effectively develop and maintain services, this will also ensure speciality, divisional and Trust-wide plans anticipate demand and capacity and ensure plans are aligned to regional and national priorities**.**

All new significant projects or programmes of work throughout the year will also routinely consider risks to the project, service, department, division or organisation through the Trust's EQuality Impact Assessment (EQIA) process. Project risk assessments will consider potential positive and negative impacts.

4.18 Restricted Circulation Risks

The Trust promotes openness and transparency in the management of risk and therefore risks on Datix are generally unrestricted for all colleagues to access to promote shared understanding and triangulation.

In limited circumstances, it may be necessary to restrict open access to a risk due to the nature of it. The Trust refers to these as **'Restricted Circulation Risks'**.

Restricted Circulation Risks are those risks which specifically reference risks regarding teams or individuals in the organisation and need to be managed in a sensitive and confidential manner.

A Restricted Circulation Risk will typically be a high level cultural concern or leadership issue which may be impacting on the effective running of the team or department (potentially increasing the risk that these could result in patient safety concerns, quality of care, working relationships, grievances, team dynamics, freedom to speak up concerns, multiple Datix incidents, external review or external concerns being raised), it could involve several individuals as well as potentially there being previous attempts to bring about performance improvements or a resolution to the issues through local line management or engagement with corporate teams in the wider Trust.

Concerns in relation to potential cultural concerns that could require a Restricted Circulation risk are escalated for discussion by Divisional Management Teams and Executive Team members at Part II of the Divisional Improvement Forum (DIF). Restricted Circulation Risks can only be approved at the discretion of the Executive Team, ordinarily as Part II of the Divisional Improvement Forum. However, in the event that a risk is identified and there is an urgent need to record and escalate a Restricted Circulation risk, this can be approved by an Executive Director.

The reporting of a Restricted Circulation risk supports the Trust in understanding Trust-wide culture, being able to work collaboratively to address risks, undertake organisation wide and system wide learning from issues in order to improve the quality of care, patient safety and staff experience. Importantly, the discussion and management of these risks is recorded through the relevant DIF Part II meeting. An overview of Restricted Circulation Risks are also reported to:

- Executive Management Team meeting.
- Raising Concerns Group at each meeting.
- Workforce Committee as a Restricted Agenda item at each meeting.
- Part II of the Board of Directors meeting bi-annually.

All colleagues have an obligation to report risks to allow the organisational system to improve and create a restorative just and learning culture, where issues are dealt with proactively, in collaboration and without fear of retribution.

Risks can be recorded by selecting that this is a restricted circulation risk when entering the risk on Datix. All risks recorded this way are checked by the Corporate Governance team who have enhanced access and can activate the risk once formally approved. In the event this has been selected erroneously, the Corporate Governance team can remove this.

Appendix 8 outlines the Risk Management Process for Restricted Circulation Risks.

4.19 Dissemination and Implementation

This Policy will be distributed and communicated as outlined in the Distribution Plan section.

5. AUDIT AND MONITORING

Risk reporting and monitoring is in place within each Division through a Governance Dashboard with specific key performance indicators including risk, audit, and incident and safeguarding management.

Performance against key governance and risk metrics are monitored at Divisional Improvement Forums with a high risks dashboard for each Division presented at the Risk Management Group to facilitate organisational wide review and learning.

Where gaps are identified actions are put in place to improve performance as required. Performance indicators and benchmarks are routinely refined and updated.

As part of the Trust's Risk Management Strategy and Policy, it is expected that all clinical Divisions will conduct an annual review of risk management activity, using a bespoke risk maturity matrix, building on a respected Institute of Internal Audit model, a process facilitated by the Governance Managers & Leads in each division. This tool is recognised by the Trust's Internal Auditors Mersey Internal Audit Agency (MIAA) and considers the following factors as part of the review to provide an assessment of the embeddedness and effectiveness of the risk management processes being applied by the Divisions.

- Leadership, management & culture.
- Roles & Responsibilities.
- Processes.
- Monitoring & feedback.

The overall conclusions are broadly made against the following risk maturity definitions:

Level 5
Risk enabled

Driven by the Board, staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks / risk management and internal controls fully embedded into the operations.

Level 4
Risk managed

Staff throughout the organisation are aware of the importance and the organisations response to risk Enterprise approach to risk management developed and communicated.

Level 3
Risk defined

The organisation has considered risk management, and put in place strategies led from a risk management team / strategy and policies in place and communicated. Risk appetite defined.

Level 2
Risk aware

The organisation is aware of risk management responsibilities, and needs to embed systems/ scattered silo based approach to risk management.

Level 1
Risk naive

The organisation has little or no awareness of the importance of risk management / no formal approach developed for risk management.

The Board of Directors receive assurance on the effectiveness of the organisation's Risk Management Processes from the Audit Committee which is informed by the annual Assurance Framework review undertaken by the Internal Auditors, and the Head of Internal Audit Opinion. This in turn informs the Annual Governance Statement.

Arrangements are also made as part of the Annual Internal Audit Plan agreed by the Audit Committee, for periodic audits to be carried out to provide assurances to the Board that the Risk Management System in place conforms to the required standards.

6. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? **Risk Management training is covered in section 4.13. The training includes key parts of the policy.**

7. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
Appendix 1	Trust Corporate Governance Committee Structure
Appendix 2	Risk management reporting arrangements
Appendix 3	The Risk Assessment and Management Process Guidance
Appendix 4	Risk Assessment and Risk Management Process Flow Chart
Appendix 5	Summary of the Risk Register Data Fields
Appendix 6	Risk Review Report Template
Appendix 7	NPSA Scoring Matrix
Appendix 8	Protocol for managing Restricted Circulation Risks
Appendix 9	Equality and Diversity Impact Assessment Tool

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
RMP-HS-102	Risk Assessment and the Process for Use of Risk Registers
TP-27	Policy and Procedure for Handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses
SOP-394	Complaints Policy and Procedure
TP-113	Clinical Audit Policy and Procedure
RMP-C-98	Implementation and Management of NICE Guidance
RMP HS 114	Adverse Incident Reporting, Management and Investigation Policy and Procedure
TP-16	Health and Safety Policy
TP-149	Being Open Policy (incorporating Duty of Candour and PSIRF engagement)
RMS-13	Risk Management Strategy 2024-2027

RMP-C-278	Patient Safety Incident Response Framework (PSIRF) Policy
Plan-27	Patient Safety Incident Response Plan (PSIRP)
TP-219	EQuality Impact Assessment (EQIA) Policy
LTHTR	Single Improvement Plan
LTHTR	Risk Management and Maturity
LTHTR	Strategic Decision Making Support Tool

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full checked by the library 07/04/2025 SR**	
Number	References
1	Lancashire Teaching Hospitals NHS Foundation Trust Provider Licence https://www.lancsteachinghospitals.nhs.uk/media/.resources/61265fa0599f96.90560040.pdf
2	Care Quality Commission - Single Assessment Framework (2024) https://www.cqc.org.uk/news/our-new-single-assessment-framework
3	Department of Health & Social Care website https://www.gov.uk/government/organisations/department-of-health
4	NHS England website https://www.england.nhs.uk/
5	NHS Resolution website https://resolution.nhs.uk/
6	Care Quality Commission - The Fundamental Standards (2024) https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards
7	National Patient Safety Agency (2008) *A risk matrix for risk managers*. London, NPSA.
8	The Government Orange Book: Management of risk-Principles and Concepts (2024) https://www.gov.uk/government/publications/orange-book
Bibliography	
NHS Commissioning Board (2013) *Reservation of Powers to the Board & Delegation of Powers.*	
NHS Litigation Authority (2013) *NHSLA Risk Management Standards 2013-14.* London, NHSLA.	
The Management of Health and Safety at Work Regulations 1999 https://www.legislation.gov.uk/uksi/1999/3242/contents/made	
Patient Safety Incident Response Framework (updated 2024) https://www.england.nhs.uk/long-read/patient-safety-incident-response-framework/	
Patient Safety Incident Response Framework supporting guidance: Engaging and involving patients, families and staff following a patient safety incident (2022) https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf	

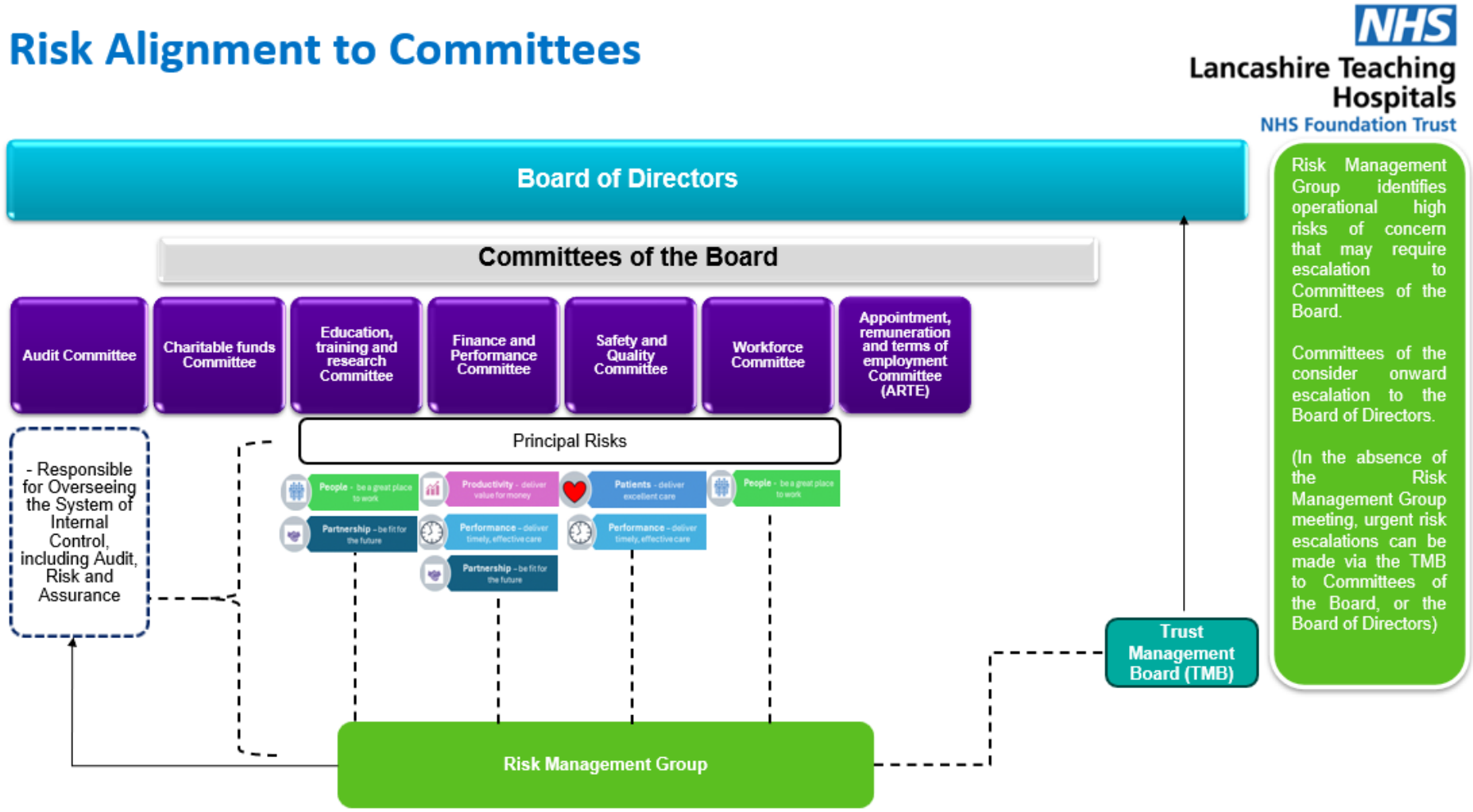
DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
ALARP	As Low As Reasonably Practicable

BAF	Board Assurance Framework
CQC	Care Quality Commission
HSE	Health and Safety Executive
MHRA	Medicines and Healthcare Products Regulatory Agency
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
TNA	Training Needs Analysis
TMB	Trust Management Board

CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
Board of Directors		Planned - June 2025
Audit Committee		Planned - April 2025
Risk Management Group		April 2025
Divisional and Corporate Leadership Teams and Executive Management Team		March 2025
Divisional Governance Teams		March 2025

DISTRIBUTION PLAN	
Dissemination lead:	Deputy Associate Director of Risk and Assurance
Previous document already being used?	Yes
If yes, in what format and where?	Electronic, heritage library system, hard copy
Proposed action to retrieve out-of-date copies of the document:	Knowledge and library to replace with updated version. Any paper copies to be removed and placed in confidential waste.
To be disseminated to:	Trust wide
Document Library	Heritage
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 1 TRUST CORPORATE GOVERNANCE COMMITTEE STRUCTURE



FEEDER GROUPS TO COMMITTEES OF THE BOARD

Education, Training and Research Committee
Apprenticeships Strategy and Assurance Committee; Training Compliance and Assurance Committee; Education Quality and Performance Subcommittee; Education Finance and Business Subcommittee; Research and Innovation Subcommittee.
Finance and Performance Committee
Capital Planning Forum; Emergency Preparedness, Resilience and Response (EPRR) Committee; Information Governance and Records Committee; Senior Information Risk Owner/Asset Information Owner Working Group; Digital and Health Informatics Divisional Board; ICS, ICB and PCB system updates.
Safety and Quality Committee
Infection Prevention and Control Group; Safeguarding Board; Mortality and End of Life Care Committee; Medicines Governance Committee; Patient Safety Incident Response Framework (PSIRF) Oversight Panel; Patient Experience & Involvement Group; Health and Safety Governance.
Workforce Committee
Health and Wellbeing Group; Temporary Staffing Group; Raising Concerns Group; Equality, Diversity and Inclusion Group, Divisional Improvement Forum (DIF) Part II.
Audit Committee
Risk Management Group

Appendix 2 - RISK MANAGEMENT REPORTING ARRANGEMENTS

Document	Presented to	Frequency	By
Board Assurance Framework	Board of Directors	At each meeting	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Board Assurance Framework	Audit Committee	At each meeting	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Strategic Risk Paper – Principal Risks	Committees of the Board	At each meeting where an aligned risk exists	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Operational High Risk Register	Risk Management Group	At each meeting	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Risk Management Policy	Board of Directors	Annually	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Escalation of operational high risks of concern from Risk Management Group (or Trust Management Board meeting should the Risk Management Group not meet and urgent escalation is required)	Committees of the Board	At each meeting (as required – included in Strategic Risk Paper)	Executive Lead (supported by Corporate Governance Team)
Annual Governance Statement	Audit Committee	Annually	Director of Corporate Affairs/Associate Director of Risk and Assurance

Document	Presented to	Frequency	By
DIF Part II Chairs Report – Restricted Circulation Risks	Workforce Committee	At each meeting (in Restricted Agenda)	Divisional Management Team
Restricted Circulation Risks Report	Divisional Improvement Forums	At each meeting (in Part II) (Except if deemed not required by the Chair)	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Divisional Risk Reports	Risk Management Group	At each meeting (on a cycle)	Divisional Management Team
Governance Dashboard	Divisional Improvement Forums	At each meeting	Divisional Management Teams

See Appendix 8 for further information on Restricted Circulation Risk Reporting arrangements.

Appendix 3 - THE RISK ASSESSMENT & MANAGEMENT PROCESS GUIDANCE

1. Identifying the Risks to Objectives:

Risks can be identified from a variety of different sources through the operation of the Trust's business; these sources can include, but are not limited to:

Proactive Processes:	• Planning Processes • General Observations • Internal/External Audits
Reactive processes:	• Incidents • Complaints • Claims • Inspections/Assessments/Accreditations/Reviews • Regulatory Assessments

2. Types of Risk

Risks to Safety:	• Risks that could result in harm or severe distress to patients, visitors, contractors and/or staff. • Risks that may be less serious but are more frequent or could affect a large number of patients/staff.
Risks to Reputation:	• Risks that could lead to adverse publicity or affect the reputation of the Trust. • Risks that could lead to litigation or may be the cause of a formal complaint. • Risks that could affect the Division / Department / Trust in meeting corporate objectives (e.g. failure to meet service delivery targets / operational loss or delay / national requirements).
Risks to Resources:	• Risks that could result in financial loss to the Trust. • Risks to service provision. • Risks to equipment / buildings. • Risks to staff retention.

3. Risk Handler and Risk Owner:

When a risk is identified, a Risk Handler and Risk Owner must be assigned to take responsibility for the assessment and ongoing management of the risk and the actions to mitigate the risk.

The Risk Handler	should be the person that will have 'day-to-day' responsibility for the assessment and management of the risk and updating the Datix System, as such Risk Handlers

	must have the requisite authority to make the required decisions.
The Risk Owner	should be the person that will have 'managerial' responsibility for the oversight of the risk. They will also provide direction and management support where appropriate to the Risk Handler; as such Risk Owners must have the requisite authority to make the required decisions.

Below is simplified example of the types of Risk Handlers and Owners that might occur in a nursing, medical and service management context but these are examples and not prescriptive as each risk is different.

Nursing	Risk Handler	Risk Owner
Intra-Divisional Escalation	Ward Manager/Sister	Matron
	Matron	Deputy Divisional Nurse Director
Extra-Divisional Escalation	Deputy Divisional Nurse Director	Divisional Nurse Director
	Deputy Chief Nursing Officer	Chief Nursing Officer
Medical	**Risk Handler**	**Risk Owner**
Intra-Divisional Escalation	Consultant	Clinical Lead
	Consultant/Clinical Lead	Clinical Director
Extra-Divisional Escalation	Clinical Director	Deputy Chief Medical Officer
	Deputy Chief Medical Officer	Chief Medical Officer
Service Management	**Risk Handler**	**Risk Owner**
Intra-Divisional Escalation	Department/Unit/Ward Manager	Specialty Business/Clinical Business Unit Manager
	Specialty Business/Clinical Business Unit Manager	Divisional Director
Extra-Divisional Escalation	Divisional Director	Deputy Chief Operating Officer
	Deputy Chief Operating Officer	Chief Operating Officer

4. Risk Assessments and Systematic Approach

A Risk Assessment is the evaluation of any risk that has been identified that can interfere with the achievement of a Trust objective. These assessments are a vital part of identifying what is being done to mitigate risks, how effective this mitigation is in practice and what further mitigation is required.

Where possible risk assessments can and should be directly entered into the Datix system to avoid unnecessary duplication of effort.

All Risk Assessments must include the following:

- The Location of the risk (Division, Department, Specialty and Site).
- The Risk Handler and Risk Owner.
- The Trust Strategic and Corporate Objective that are at risk.
- The date the risk was identified.
- The risk title and description of the Risk.
- The source of the risk i.e. how the risk has come to be identified.
- The controls that are in place to assist in securing delivery of the objectives or Key Performance Indicators.
- The assurances that enable evidence to be gained that our controls are effective.
- The current risk rating - the risk rating with the current controls in place.
- The source of the risk.
- The mitigating actions that are being taken to reduce the risk that will improve the level of control and assurance on the risk.
- The target residual risk rating - the risk rating when the mitigating actions are completed.
- The review history.
- Any supporting documents or evidence attached to the Risk.

All newly created divisional risks are held in a 'Pending Tray' to allow for a Quality Assurance check by Divisional/Corporate leaders/Governance teams. The purpose of the 'pending tray' is to prevent the inadvertent addition of duplicate existing risks and to ensure that risk assessments have been completed to the standard required by this Policy.

The decision to approve or decline a Risk from the 'Pending Tray' will be taken by Division/Speciality leads in conjunction with Divisional/Corporate Governance leads. This will usually be undertaken as part of a governance meeting. However, approval of risks should not be unduly delayed whilst waiting for meetings to occur as to do so may prevent timely escalation of the risk. Where a risk is identified as scoring 15 or above at the time of the initial assessment to add this to the risk register, this should be approved in consultation with the relevant member of the Divisional Management Team, or Corporate lead, and the relevant Divisional / Corporate governance lead.

Once approved, the risk should be marked as an 'Active risk' by selecting this in the 'Approval status after save' drop-down menu on Datix, and adding the date of approval where indicated. This will add the risk to the risk register and ensure that the risk is included in risk register reports.

5. Risk Title

Risks must be titled in a clear and concise way and localised as much as possible to avoid confusion with similar risks across the organisation E.g. [Brief Description] at [localised name] e.g., Staffing levels on Ward 12.

6. Description of the risk and the consequences of the risk occurring

It is important that Risk Descriptions are both concise and contain sufficient information to allow a reader to understand the risk. The Risk description should include a summary of the risk ('There is a risk that …'), details of what is causing it ('because of (or due to) ….'), and the potential or actual consequence ('which could result in…').

Some examples of 'There is a risk that……which is due to/because of…which could result in…' risk descriptions are detailed in the table below:

There is a risk that	Because of (or due to)	Which could result in
Avoidable falls will continue to increase	Increasing patient acuity, nursing vacancies, lack of consultant cover and lack of access to preventative equipment.	Severe harm to patients, poor patient and staff experience, regulatory intervention, increase in complaints and legal claims.
Patients may wait too long for admission to hospital	Increasing patient acuity, increased attendances at the Emergency Department, increase in patients not meeting the criteria to reside in hospital, insufficient community capacity to support safe discharge.	Harm to patients, poor patient and staff experience, regulatory intervention, increase in complaints and legal claims.
There will be insufficient leadership capacity in the organisation	Lack of leadership development programmes, insufficient training budget, inability to release staff due to capacity pressures.	An inability to retain and recruit leaders, poor staff experience, inability to deliver services, regulatory intervention.
Equipment will fail	Lack of maintenance contract, parts becoming obsolete.	Inability to deliver the service, delays in important procedures, harm to patients, poor patient and staff experience, regulatory intervention, increase in complaints and legal claims.

IMPORTANT Do's and Don'ts when writing a risk description:

- **Do** include objective statements and facts.
- **Do not** include subjective personal opinions and views.
- **Do not** include abbreviations and acronyms, unless they are in very common usage e.g. NHS.

- **Do not** include Personal Identifiable Data of Patients or Visitors in the Risk Description.
- **Do not** include Personal Identifiable Data of colleagues in the Risk Description.
- **Do not** include data or time periods. This will mean the risk description requires regular update and could become out of date quickly.

7. Controls/Assurances

Controls are the measures in place that will help to reduce the chance of a risk occurring and the existing controls that are in place for the risk need to be detailed. It is worth taking some time with this section and perhaps consulting with colleagues to ensure that all relevant controls have been identified and documented.

Describe what controls are currently in place to control the risk, typically these include, policies, procedures, guidelines, training, formal structures and organisational arrangements, etc.

Record each control individually and identify if there are any gaps in the control (measures that are not in place but would decrease the chance of the risk occurring) and the effectiveness of that Control.

Identify and record any internal or external sources of assurance which are already in place. Examples of assurances may include performance monitoring reports, audits, reviews, incident reports, committee/group minutes etc. When considering gaps in assurance, this should include assurance measures that are not in place but also where the measurement might be in place but the assurance is not provided. For example:

- To not have a mechanism in place to monitor performance could be a gap in assurance. Typically, this would be addressed by putting something in place to measure performance – i.e. an audit report or data monitoring.
- To have a performance report in place regularly is a source of assurance but if the performance is poor, this would be considered a gap in assurance and would indicate there needs to be further controls added to improve the performance.

Below are some examples of controls and the information that should be recorded:

Control Type	Trust Procedure	Equipment	Managerial Oversight
Control	An agreement is in place with an agency to provide appropriately qualified x-ray staff	Capital replacement programme in place for Radiography equipment	Manager approves staffing rota

Gap in Control	Agency requires 7 days' notice to provide suitable staff	Equipment breakdown before date of replacement	Cannot ensure availability of staff at short notice
Effectiveness of Control	Mostly Adequate	Partly Adequate	Partly Adequate
Assurance - Internal	Monitoring of performance against agreement	Equipment has been ordered	Verbal report to senior manager
Assurance - External	Internal Audit review – substantial assurance	External assessment of equipment.	CQC inspection found staffing well managed
Gaps in Assurance	Performance is below trajectory.	Equipment maintenance and servicing is not monitored.	Assurance can only reactively identify problems not proactively address them
Adequacy of Assurance	Medium Assurance	Medium Assurance	Low Assurance

The overall effectiveness of all the controls that are in place should be determined and recorded in the Risk Register, the three levels of control effectiveness are:

- Fully Controlled
- Partially Controlled
- No Controls in Place

8. The Current Risk Score

Utilise the NPSA Risk Scoring Matrix and guidance to quantify the risk in terms of its current impact of the risk arising and the current likelihood of the risk arising. The matrix is in Appendix 7 of this Policy.

9. Mitigating Action Plans

The actions will detail how the risk will be mitigated and managed to reduce the risk and improve the level of control and assurance. All active risks should have at least one active mitigating action in progress.

When determining mitigating actions, consider the Five T's. Generally speaking, Risk management responses can be a mix of five main actions; transfer, tolerate, treat, terminate or take the opportunity – known as the Five T's. These are not prescriptive and should be used as guidance when considering mitigation actions.

- **Treat:** by far the greatest number of risks will be mitigated in this way with a positive action to treat and reduce the risk. The purpose of taking action to reduce the chance of the risk occurring is not necessarily to completely

eradicate the risk as this is not always possible, but to contain it to an acceptable level.

- **Transfer:** for some risks, when all reasonable action has been taken to mitigate the risk, the best response may be to transfer the risk to another party. Some common ways to do this could include buying insurance to cover a particular consequence for example, or by supporting a third party to take the risk in another way. Often, transferring a risk can have other impacts, such as a financial cost or lack of control in activity, so careful consideration should be given to transferring a risk to understand what impact that may have on the organisation and whether it may have any unintended consequences.

- **Tolerate:** the ability to do anything about some risks may be limited, or the cost of taking any action may be disproportionate to the potential benefit gained. This course of action is common for large external risks. In these cases, the response may be to tolerate the risk. The decision to tolerate a risk should be considered carefully and should be considered alongside the Board Risk Appetite Statement and tolerance levels. The current version can be found on the Risk Management and Maturity Intranet page. Also, section 4.12 of the policy describes what to do if the desired tolerance levels have been achieved, and a risk is considered to be reasonably controlled.

- **Terminate**: the risk by doing things differently thus removing the risk where it is feasible to do so. This could be by taking an informed decision not to become involved in a risk situation, such as terminating a service, although consideration would need to be given to what other risks this would create. Section 4.12 of the policy describes what to do if the desired tolerance levels have been achieved, and a risk is considered to be controlled.

- **Take the Opportunity:** This is a situation where you may actively take advantage of the uncertainty of a situation, as an opportunity to benefit. An example could be if there were two services that didn't have enough staff, one may take the opportunity to amalgamate those services and reduce the overall risk to both services.

Each Mitigating Action should include the items detailed in the below table:

Section	Explanation/Example
Action Type	Staff training – selected from a drop-down list
Action Title	Training Plan
Action Owner	Normally but not always this is the 'Risk Assessor' e.g. Relevant Ward Manager
Person Responsible	This is the person who will complete the action e.g. relevant Practice Educator
Start Date	The date the action will start on
Reminder Date	The date on which a reminder for the action to be completed should be issued, normally this would be a week or a month before target date, this date can be changed if required

Target Date	The date the action should be completed by. This date can be changed if required, the rationale for extending actions should be recorded.
Action Status	Ongoing, Closed, Removed - selected from a drop-down list
Action Completed Date	The date the action was completed upon

The 'Person Responsible' for the completion of the action should record progress towards completion on a regular basis, preferably as the progress occurs.

The 'Action Owner' should scrutinise the progress reported by the 'Person Responsible' to ensure it is of sufficient quality and to ensure that regular progress is being recorded.

Overdue progress updates can be escalated to:

- Divisional Governance Meetings.
- Associate Director of Risk and Assurance.
- Risk Management Group
- Committees.

Key aspects to consider when developing an action plan in order to mitigate/reduce the risk are summarised below.

- What are the existing controls?
- Are there any gaps?
- What further controls are practical and sustainable? (Check with staff who work in the area).
- Is the design of the control right? Is it helping you achieve your objectives?
- What further actions are needed to manage the risk?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action Plans should be focused on gaps in controls and should include the following:

- A list of any actions that are needed to manage the risk indicating the agreed time scale for each action.
- A designated person must be identified to take responsibility for each action on the list.
- Each action identified should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely).
- Action plans must be appropriate to the level of the current risk.
- Action target dates and risk review dates should be set in accordance with the level of risk, and compliance with these must be monitored appropriately through the relevant committee.

10. Risks outside of Division / Department / Trust's Control

The NHS operates within a complex and dynamic environment where risks can significantly impact service delivery, patient care, and operational efficiency. These risks can arise from factors beyond the direct control of any single Division, Department, or Trust, necessitating a proactive and adaptive approach to risk management.

To enable scrutiny of such risks and the potential solutions, it is possible to highlight risks that are considered to be outside of the control of Divisions / Departments / the Trust as follows:

- **Risks outside of a Division / Department's control but within Trust's overall control:** such risks will usually require a collaborative approach with colleagues in other Division's / Departments and may also require some input from Trust-wide leads and Corporate Departments to support the necessary mitigations to control the risk.

- **Risks outside of a Division / Department's control, and outside of the Trust's overall control:** such risks usually originate outside the immediate operational remit of the Division, Department, or the Trust but have a direct or indirect impact on their functions. Examples may include risks that have arisen due to Commissioning.

11. Target Risk Rating

All identified risks will be required to have a target score which is the level of risk that may be tolerated in order to consider a risk reasonably controlled. Each risk will be aligned to a Strategic Objective and the target score should be considered in line with the Boards agreed Risk Tolerance relevant to the Strategic Objective. The current version can be found on the Risk Management and Maturity Intranet page.

12. Risk Monitoring and Review

It is mandatory that all risks have a defined review frequency and scheduled review date that is compliant with the guidance detailed in Appendix 4.

When a risk review is due the Risk Handler is expected to undertake a review of the risk and its associated actions to ensure that appropriate mitigation action is in progress and that the risk is updated accordingly. They should complete the risk review action automatically created by Datix to cover:

- Review Date.
- Reviewed By.
- Details of Review.

The Risk Owner is expected to provide appropriate oversight and scrutiny over the work undertaken by the Risk Handler. Divisional / Departmental meetings are also

expected to provide appropriate oversight and scrutiny of their risks, especially risks that are rated as 'High.'

Overdue risk reviews are escalated to:

- Divisional Governance Meetings.
- Risk Management Group
- Head of Risk and Datix Systems
- Deputy Associate Director of Risk and Assurance.
- Associate Director of Risk and Assurance.

The Datix system stores all previous risk reviews as evidence to show the progress taken in updating and mitigating this risk.

13. Risk Archiving and Record Management

The record of a risk, including all its previous versions, from its creation through the period of its 'active' management, then into its 'inactive' archive retention is fully maintained within the Datix system. This includes all risks that have been added to Datix system since it went "live". All these records are available within the Datix system and can be immediately accessed if required.

To ensure the easy identification and reporting of 'active' risks, all risks in the Datix system are assigned one of the following statuses as is appropriate:

- Pending – The risk is in 'pending' tray and is still under assessment.
- Active – The risk is 'assigned' to a 'Handler' and 'Owner' and it is being actively mitigated.
- Controlled– The risk has appropriately mitigated and has been controlled and archived.

The Trust Risk Register can be 'filtered' to show all the risks that are allocated each of the above statuses. 'Assigned' risks can also be 'filtered' by the Division or the Site they have been allocated to.

Appendix 4 – RISK ASSESSMENT AND RISK MANAGEMENT FLOW CHART PROCESS

Risk Management – Trust Risk Register, Life Cycle and Process

Ongoing Risk Register Processes: Risk Review, Quality Assurance and Reporting (Oversight and Scrutiny)
Risk -> Risk Review -> Quality Assurance -> Reporting: Oversight and Scrutiny

Risk Identification Assessment and Acceptance	
Risk Identification	Local Level: Variety of means and methods staff are encouraged to identify and report risks
Entry on to Risk Register	Local Level: Risk Identifier, Risk Assessor or Risk Manager
Quality Assurance Check	Divisional Governance Lead and/or Corporate Governance team, ensures appropriate standards
Acceptance	Divisional Governance Meeting and/or Divisional/ Speciality leads in conjunction with Divisional/Corporate Governance leads

	Handler	Owner	Gov Lead	Corp .Go	Dept/Ward	Divisional	Committee	Trust Board
Low Risk Score 1-3	Yes	Yes	Periodic Assessment depends on size of Division / Department	Periodic Assessment as Required / Identified	Yes	Periodic Reporting depends on the size of the Division / Department	Periodic reporting as appropriate within Board reporting template	Periodic reporting as appropriate within Board reporting template
Moderate Risk Score 4-6	Yes	Yes	Periodic Assessment depends on size of Division / Department	Periodic Assessment as Required / Identified	Yes	Periodic Reporting depends on the size of the Division / Department	Periodic reporting as appropriate within Board reporting template	Periodic reporting as appropriate within Board reporting template
Significant Risk Score 8-12	Yes	Yes	Yes	Periodic Assessment as Required / Identified	Variable depends on the nature of Risk	Periodic Reporting depends on the size of the Division	Periodic reporting as appropriate within Board reporting template	Periodic reporting as appropriate within Board reporting template
High Risk Score 15-25	Yes	Yes	Yes	Yes	Variable depends on the nature of Risk	Yes	Yes as per escalation	Yes as per escalation from committee

Controlled Risks	
Controlled Risk Request	Local Level: Risk Assessor or Risk Manager
Quality Assurance Check	Divisional Governance Lead and or Corporate Governance Team, ensures appropriate standards.
Decision	Divisional Governance Meeting and/or Divisional/ Speciality leads in consultation with Divisional/Corporate Governance leads

Risk Review Frequency Guidance

The frequency of review for a Risk should be based upon the profile and seriousness of that Risk. The below table provides guidance on normally appropriate review frequencies based upon the Risk Rating of the Risk.

Risk review Frequency			
Risk Rating / Score	**Minimum Frequency**	**Maximum frequency**	**Range or Review Frequencies**
Low Risk 1- 3	Annual	Quarterly	Annual, Six Monthly, Quarterly
Moderate 4- 6	Quarterly	Bi - Monthly	Quarterly, Bi-Monthly
Significant 8-12	Quarterly	Monthly	Quarterly, Monthly
High Risk 15-25	Monthly	Daily	Monthly, Bi-weekly, Weekly

NPSA Risk Matrix – for reference

	Likelihood Score				
Consequence Score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Review Process	
Automated Process Manual Checks	All Risks have a specified Risk Review Date that is compliant with the review frequency. Reminder email auto-generated 3 days before review date, on review date and each 7 days after review date.
Reviewers	Risk Handlers should review and update the Action Plan and Control Status of the Risk. Risk Owners should review and challenge the information provided by the Risk Assessor.
Quality Assurance	Divisional Governance Lead (or Corporate Governance team) assess the quality of the reviews undertaken by the Risk Handler and Owner and provide feedback and advice as required.
Reporting: Oversight and scrutiny	Oversight and Scrutiny of the Risk Register is carried out from 'Ward to Board.' Multiple oversights for higher scoring Risks are provided at Divisional, Committee and Board Level.

Appendix 5 – SUMMARY OF THE RISK REGISTER DATA FIELDS

Orange denotes mandatory fields; grey denotes system generated fields, white are not mandatory.

Section	Data Item
System Data	Risk Number
	Risk Level
	Current Status
Location Details	Division
	Site
	Department
	Specialty
Manager Details	Risk Handler
	Risk Owner
Link to Objectives	Trust Ambition/Aim
	Trust Sub-Ambition/Sub-Aim
	Risk Theme
	Oversight Committee
Risk Details	Date Identified
	Risk Title
	Risk Description
Existing Controls in Place	Details of Control
	Gaps in Control
	Effectiveness of Control
	Assurance – Internal
	Assurance - External
	Gaps in Assurance
	Adequacy of Assurance
	Overall Control
	5Ts Status

Section	Data Item
Current Risk Assessment	Current Risk Consequence Score
	Current Risk Likelihood Score
	Current Risk NPSA Rating
	Source of Risk
Action Plans	Action Title / Summary
	Action Detail
	Action Owner
	Start Date
	Due Date
	New Progress
	Action Status
	Action Completed date
Target Risk Levels	Target Risk Control Date
	Target Risk Consequence Score
	Target Risk Likelihood Score
	Target Risk NPSA Rating
Risk Review	Review Frequency
	Next Review Date
	Review Date
	Reviewed By
	Details of Review
Supporting Documentation	Any Items of Supporting Documentation that have been added

Appendix 6 – RISK REGISTER REVIEW TEMPLATE

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Risk ID:	Risk Title:	Risk Description						
Strategic Objective:		Risk Grades:	Initial		Current		Target	
Corporate Objective:		Risk Rating Tracker						
Risk Owner								
Risk Handler								
Committee								
Controls		Assurances			Actions Plan / Progress Notes			
Gaps in Controls		Gaps in Assurances			Review Update Description			

N.B. The report format produced from Datix will include all of the above data fields but will have a slightly different structure, due to the technical parameters of the reporting function within Datix.

Appendix 7 – NPSA SCORING MATRIX

Table 1a Consequence scores (Impact or severity)
Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Other domains should be considered to determine if there are any other consequences which could influence the severity.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training/key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract/ payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 1b (additional guidance and examples relating to risks impacting on the safety of patients, staff or public)

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable event An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse effects Physical attack such as pushing, shoving or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work required)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information /communication on transfer of care Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in injury such as a sprain	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long-term HCAI Retained instruments/ material after surgery requiring further intervention Haemolytic transfusion reaction Slip/fall resulting in injury such as dislocation/fracture/ blow to the head Loss of a limb Post-traumatic stress disorder Failure to follow up and administer vaccine to baby born to a mother with hepatitis B	Unexpected death Suicide of a patient known to the service in the past 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Removal of wrong body part leading to death or permanent incapacity Incident leading to paralysis Incident leading to long-term mental health problem Rape/serious sexual assault

Table 2a Likelihood scores (broad descriptors of frequency)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently

Table 2b Likelihood scores (time-framed descriptors of frequency)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Table 2c Likelihood scores (probability descriptors)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Scoring and Grading

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use **table 1a or 1b** to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use **table 2a** determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome (**table 2b**). If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode (**table 2c**). If a

numerical probability cannot be determined, use the probability descriptions to determine the most appropriate score.

4. Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score) The risk matrix in **table 3** shows both numerical scoring and colour bandings. For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	Significant risk
15 - 25	High risk

Appendix 8 – PROTOCOL FOR MANAGING RESTRICTED CIRCULATION RISKS

The Trust promotes openness and transparency in the management of risk and therefore risks on Datix are generally unrestricted for all colleagues to access to promote shared understanding and triangulation.

In limited circumstances, it may be necessary to restrict open access to a risk due to the nature of it. The Trust refers to these as **'Restricted Circulation Risks'**.

A "Restricted Circulation Risk" is one which specifically references risks regarding teams or individuals in the organisation and requires managing in a sensitive and confidential manner.

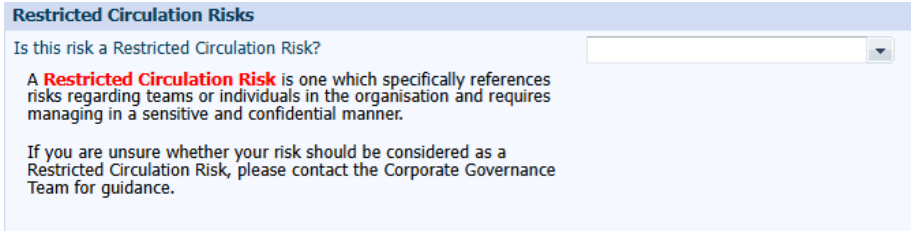
A Restricted Circulation Risk typically will be a high level cultural concern or leadership issue that is likely to have an impact on the effective running of the team or department (such as patient safety concerns, quality of care, working relationships, grievances, team dynamics, freedom to speak up concerns, multiple Datix incidents, external review or external concerns being raised), it could involve several individuals as well potentially there being previous attempts to bring about performance improvements or a resolution to the issues through local line management or engagement with corporate teams in the wider Trust.

Restricted Circulation Risks support the Trust in understanding our culture, being able to work collaboratively to address risks, undertake organisation wide and system wide learning from issues in order to improve the quality of care, patient safety and staff experience.

This protocol provides a framework to ensure appropriate actions are taken to manage Restricted Circulation Risks. All colleagues have an obligation to report risks to allow the organisation to improve and create a restorative just and learning culture, where issues are dealt with proactively, in collaboration and without fear of retribution.

Datix System Configuration

Restricted Circulation Risks will be recorded using Datix as it is an established risk reporting system. The risk register form design on Datix has a section at the point of input of any new risk which enables the risk to be identified as a Restricted Circulation Risk (a Yes/No field). This is accompanied by a definition of what is classed as a Restricted Circulation Risk on the form design to guide Datix users.



Should the Restricted Circulation Risk be related to an individual(s), no names of staff would be included in risk record descriptions or within controls or assurances to maintain the utmost confidentiality.

To alleviate concerns that a Restricted Circulation Risk record could be tampered with to make a Restricted Circulation Risk accessible by all, the question on Datix indicating that the record is a Restricted Circulation Risk will be made 'Read Only.' A request for any change on this field would need to be made to the Head of Risk & Datix Systems who can amend, thus making the record secure. Should the Head of Risk & Datix Systems be unavailable, the request should be made to the Associate Director of Risk & Assurance or the Deputy Associate Director of Risk & Assurance.

Access

A series of permission security groups, which are applied to the profile set up on the Datix System Administration, grant or deny access to such Restricted Circulation Risks based upon a user's job role as specified by Executives in October 2021.

The series of permission security groups are designed to protect the confidentiality of the risks, especially when it could be relating to specific teams or individuals. It is important that confidentiality is always maintained when recording and discussing these risks in order to protect the individuals involved as it is likely the situation will be personally and professionally challenging for them and we need to treat colleagues with dignity and respect, finding ways to support improvement and learning in a transparent manner. The Restricted Circulation Risk reporting process should not be seen as a 'sanction' or 'prejudgement' as this will go against the culture we are trying to create of compassion, no blame, learning, involving colleagues in improvements, giving colleagues a voice and shared accountability.

The following groups of staff will be given access to Restricted Circulation Risks:

- Divisional Management Teams (DND/DMD/DD) and HR Business Partner for the Division the risk is aligned to.
- Executive Team.
- Deputy Chief People Officer.
- Corporate Governance and Risk Team on a need to know basis for reporting purposes.

Any exceptions to this will be discussed and agreed with the Head of Risk & Datix Systems and can also be approved by the Associate Director of Risk & Assurance, Deputy Associate Director of Risk & Assurance, Deputy Chief People Officer, or the Executive Team.

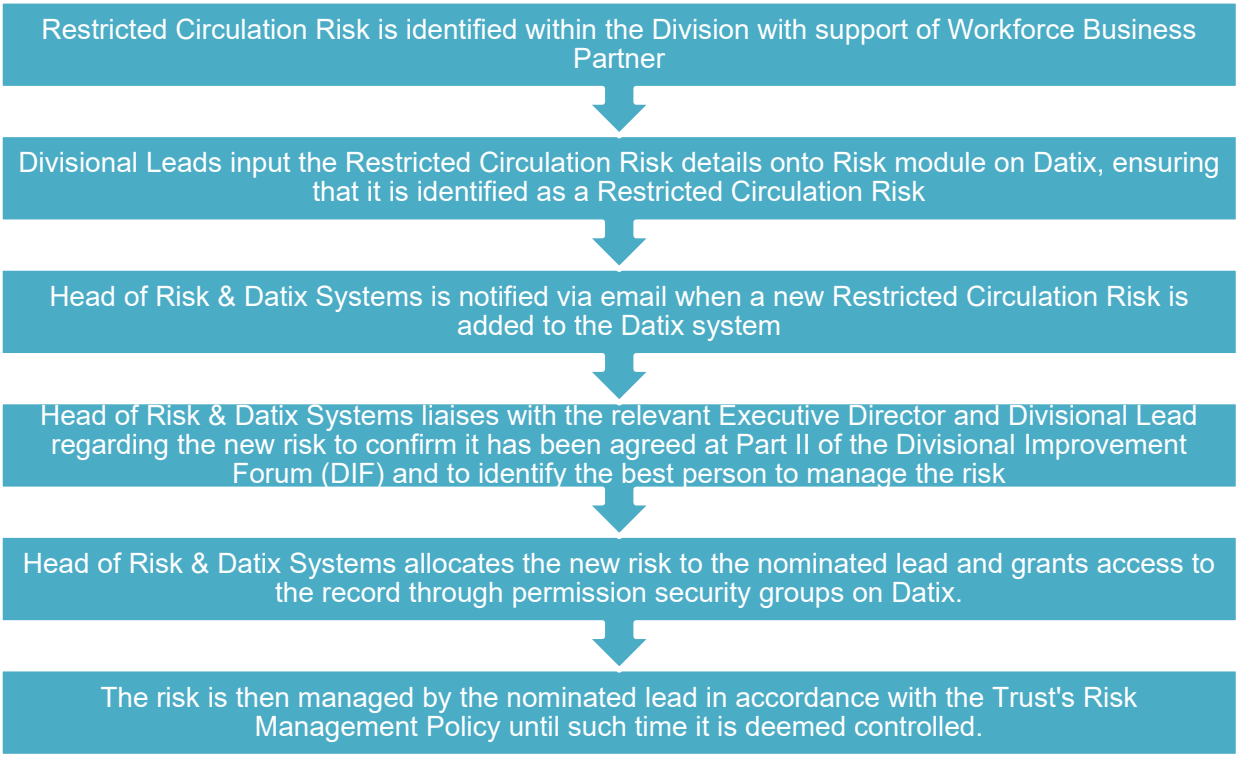
Security Group Number	Security Group Title	Security Group permission
1	RISK – Access – Access to all Restricted Circulation risks	Provides access to all risks identified as being a Restricted Circulation risk

Security Group Number	Security Group Title	Security Group permission
2	RISK – Access Denied – Access Denies to all Restricted Circulation risks	Denies access to all risks identified as being a Restricted Circulation risk
3	RISK – Access – Access to Restricted Circulation risks in user's Division	Provides access to all risks identified as being a Restricted Circulation risk within the Division that is detailed on the user's account
4	RISK – Access Denied – Access denied to Restricted Circulation risks not in user's Division	Denies access to all risks identified as being a Restricted Circulation risk that are outside the Division that is detailed on the user's account
5	RISK – Access – Access to Restricted Circulation risks where named as Handler	Provides access to all risks identified as being a Restricted Circulation risk within the Division that are allocated to the user as Handler
6	RISK – Access – Access to Restricted Circulation risks where named as Owner	Provides access to all risks identified as being a Restricted Circulation risk within the Division that are allocated to the user as Owner
7	RISK – Email – Email notification when a new Restricted Circulation risk is recorded on Datix	Datix will send an automatic email when a new Restricted Circulation risk is recorded on the Datix system.

Management of Restricted Circulation Risks

The flow chart in figure 1 depicts the Restricted Circulation Risk management approach.

Figure 1 – Restricted Circulation Risk Management Flowchart



Roles and Responsibilities

Divisions

- Divisional Directors (Divisional Nursing Director, Divisional Medical Director or Divisional Director) are responsible for escalating any Restricted Circulation Risk at the Part II DIFs, and seeking agreement that they should be placed on the Restricted Circulation Risk section of the Risk Register on Datix. It is acknowledged that it may not always be clear what may be classed as a Restricted Circulation Risk in the early stages of concerns being identified and Divisional Directors should feel comfortable to raise any concerns during the Divisional Improvement Forum Part II discussion about Restricted Circulation Risks to have an open conversation about concerns and if the risk needs to be progressed through this process.
- The Divisional Directors (Divisional Nursing Director, Divisional Medical Director or Divisional Director) are responsible for ensuring that Restricted Circulation Risk information is recorded appropriately on Datix and ensuring that the risk is managed on Datix in line with the Trust's Risk Management Policy.
- The Division is responsible deciding who the nominated lead is for formulating and managing an action plan in response to the Restricted Circulation Risk identified, making sure that the risk is updated on Datix to reflect progress.

- The Division is responsible for seeking additional support to progress or inform any action plan such as from the Freedom to Speak Up Guardian, Human Factors, Continuous Improvement and Workforce and Organisational Development etc.
- The Division is responsible for making the team or individuals aware of any concerns, engaging them in sharing their view of the issues and working in partnership to bring about improvements.
- Should there be a Restricted Circulation Risk identified within the Corporate Division, due to there being no Divisional Management Team for the Corporate Division and Departments, the escalation should take place to the Executive Management Team for agreement that the Restricted Circulation Risk be placed on the Risk Register in Datix, and for oversight on managing the action plan.
- An appropriate Corporate lead will be identified to lead and manage the risk on Datix.
- The Corporate Governance team will support with guidance on inputting Restricted Circulation Risk information on Datix and ensuring that the risk is managed in line with the Trust's Risk Management Policy as required.

Workforce and Organisational Development Department

- The Workforce and Organisational Development Department will provide support, professional advice and where needed, deliver interventions to enable the action plan to be progressed.
- The Divisional Workforce Business Partner will be the liaison point in the first instance between the Division and the Workforce and Organisational Development Department, with colleagues from across the Department being engaged to support the progression of actions where needed based on their area of expertise.
- The Workforce and Organisational Development Department will be responsible for reviewing themes from all the Restricted Circulation Risks to determine wider organisational learning in partnership with the Chief People Officer, colleagues from the Risk Management Team and Freedom to Speak Up Guardian where applicable via the Raising Concerns Meeting.
- The Raising Concerns Meeting will be used to share themes and to triangulate new information, patterns or issues, and where required the Chief People Officer will escalate new concerns to the Part II meeting of the Divisional Improvement Forum for further discussion, risk recording and potential action plan development.
- Where there is a lack of progress against the action plan or improvements are not being made to team, service or individual performance despite intervention, it may be necessary for the Chief People Officer to raise concerns to the Board of Directors via the Workforce Committee or other Committees of the Board depending on the nature of the risk.

Head of Risk & Datix Systems

- The Head of Risk & Datix Systems is responsible for providing scrutiny to any newly recorded Restricted Circulation Risks and consulting the Divisional Triumvirates regarding newly recorded Restricted Circulation Risks as part of the validation and risk allocation process.
- The Head of Risk & Datix Systems will provide support through Divisional Boards – Part II for the update and review of the Restricted Circulation Risks on the Datix

system, ensuring that Risk Handlers update controls, assurance and action plans as required.
- The Head of Risk & Datix Systems will support with the provision of Restricted Circulation Risk information to Trust meetings, as required.

Expectations of Risk Content and Management

The risk description should clearly articulate what the risk is. However, should refrain from identifying any individuals to maintain the utmost confidentiality. The Controls, Gaps in Controls, Assurances and Gaps in Assurances sections should be completed as per the usual expectation for all risks in the Trust's Risk Management Policy.

It is acknowledged that an Action Plan for Restricted Circulation Risks should be formulated outside of the Datix system. In order to maintain confidentiality and in recognition of the restrictive access to the Restricted Circulation Risks, actions **must not** be recorded within the Actions Section of the Restricted Circulation Risk record on Datix. This is because Datix automatically notifies action owners and this could inadvertently breach the Restricted Circulation Risk process.

Instead, as risks are discussed at every Part II DIF meeting that takes place, it is acceptable for a document version of the Action Plan to be attached in the Documents Section of the Restricted Circulation Risk record on Datix and for updated versions to be uploaded to the Risk record over time.

Once the risk is managed to an acceptable level and the relevant assurances have been obtained that the risk is reasonably controlled, the information should be presented to Divisional Improvement Forum for approval that the risk can be controlled.

Once approval is obtained, the risk can move from "Active Risks" to "Controlled Risks" on the Datix system and the relevant information recorded to document why the risk is controlled, in the same manner for any other risk on the system.

A user guide to assist users adding a new Restricted Circulation Risk and/or managing a Restricted Circulation Risk on Datix is included at the end of this appendix.

Reporting and Assurance

Data regarding Restricted Circulation Risks is included within Divisional Risk KPIs and statistics within the Monthly Governance Dashboard on the BI Portal, however the risk level detail remains restricted in Datix and the Dashboard provides quantity data only.

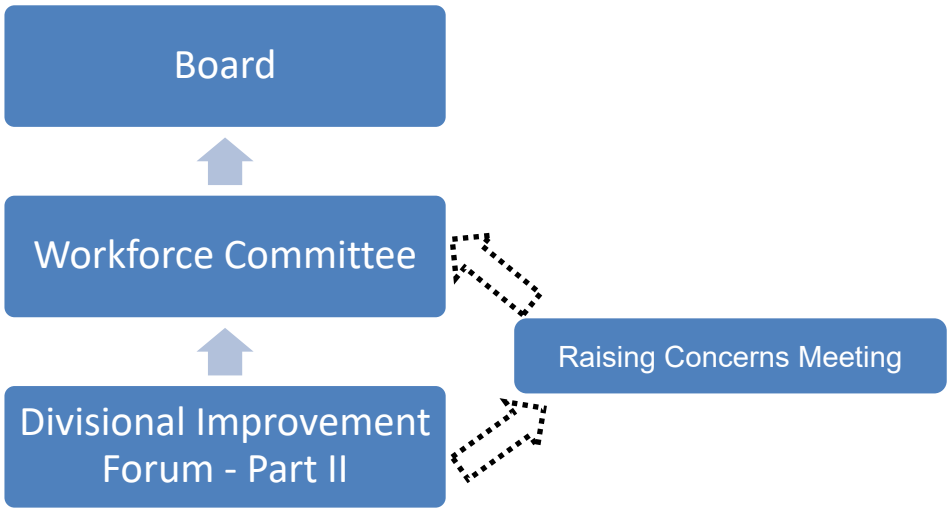
A bi-monthly Divisional Improvement Forum Part II Chair's report will be produced and presented to Workforce Committee, giving update and oversight of current scores and progress of mitigating action plans.

Cycle of Business for Reporting

The below table details the outline frequency of Restricted Circulation Risk discussion and report compilation although this will fit in with Committee/Group dates and cycles of business, which are subject to change:

	Mode	Responsibility	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Restricted Circulation Risk paper to Executive Management Team	Paper	Head of Risk & Datix Systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Restricted Circulation Risk discussion at Divisional Improvement Forum (DIF) Pt II	Discussion (with risks on screen live)	Divisional Triumvirate / Quads, Workforce Business Partners	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Scoring Restricted Circulation Risks Information to Risk Management Group	Paper (data only)	Associate Director of Risk & Assurance, Head of Risk & Datix Systems		✓	✓		✓	✓		✓	✓		✓	✓
Bi-monthly Restricted Circulation Risk Overview at Raising Concerns Group	Paper (virtual on-screen)	Associate Director of Risk & Assurance, Head of Risk & Datix Systems		✓		✓		✓		✓		✓		✓
Bi-monthly Production of DIF Part II Chair report for Workforce Committee	Chair's report	Associate Director of Risk & Assurance supported by Deputy Chief People Officer	✓		✓		✓		✓		✓		✓	
Bi-monthly Production of Raising Concerns Chair report for Workforce Committee	Chair's report	Freedom to Speak Up Guardian	✓		✓		✓		✓		✓		✓	
Overview - Board of Director's Part II	Paper	Associate Director of Risk & Assurance		✓						✓				

Flowchart of escalation of Restricted Circulation Risk information



Should Workforce Committee review the Divisional Improvement Forum Part II Chairs report and consider that a Restricted Circulation Risk is of significant concern and requiring more focused attention, the Restricted Circulation Risk can be escalated to Board Part II, through the usual Risk Management Structure at any point and this doesn't have to wait for the bi-annual update to Board Part II.

An example of the Chair's report to Workforce Committee is included at the end of this document.

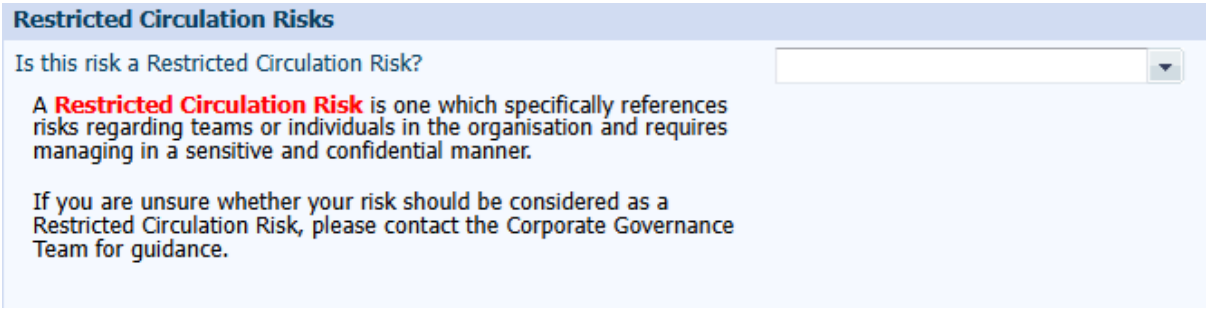
Restricted Circulation Risks – Datix User Guide

Adding a new Restricted Circulation Risk on Datix

To add a new Restricted Circulation Risk, follow the exact same process as adding any other risk to the Risk Register on Datix detailing

- Risk title
- Risk description
- Initial score
- Location of risk

Once the above is detailed, there is now an additional question enabling the identification of a Restricted Circulation Risk. This is a “Yes/No” field and to identify the risk as a Restricted Circulation Risk, select “Yes.”



Complete the rest of the new risk form identifying

- the key information regarding the risk’s identification
- whether the risk is out of the Division’s control
- whether there are any documents to attached

…and then press “Submit” at the bottom of the form.

Moving a new Restricted Circulation Risk onto the Active Register on Datix

When a new Restricted Circulation Risk is recorded on the Datix system, the system will send an automatic email notification to the Head of Risk & Datix Systems who will then liaise with the Divisional Triumvirate / Quad to check that the risk is a genuine Restricted Circulation Risk that has been agreed to be added to Datix through Divisional Improvement Part II Forum, and who should be the Risk Owner and Risk Handler. If not yet agreed through the Divisional Improvement Forum Part II process, this will be discussed at the next meeting and a decision made.

Once confirmed to be an agreed Restricted Circulation Risk, the Head of Risk & Datix Systems will place the risk onto the Active Register and will allocate the record to the necessary Risk Owner and Handler, as agreed with the Divisional Triumvirate / Quad. The Head of Risk & Datix Systems will also ensure that access is opened to the record as appropriate (see protocol for detail) and will notify the relevant Workforce Business Partner to inform them of a new Restricted Circulation Risk in their area.

Managing an Active Restricted Circulation Risk on Datix

The Restricted Circulation Risk should be managed on Datix in line with the Trust Risk Management Policy, in the same manner that any other risk would be.

All controls, gaps in controls, assurances and gaps in assurances should be documented in the appropriate sections on the risk record.

It is acknowledged that an Action Plan for Restricted Circulation Risk should be formulated outside of the Datix system. In order to maintain confidentiality and in recognition of the restrictive access, actions **must not** be recorded within the Actions Section of the Restricted Circulation Risk record on Datix. This is because Datix automatically notifies action owners, and this could inadvertently breach the Restricted Circulation Risk process.

Instead, as risks are discussed at every Part II DIF meeting that takes place, it is acceptable for a document version of the Action Plan to be attached in the Documents Section of the Restricted Circulation Risk record on Datix and for updated versions to be uploaded to the Risk record over time.

Once the risk is managed to an acceptable level and the relevant assurances have been obtained that the risk is reasonably controlled, the information should be presented to Divisional Improvement Forum Part II for approval that the risk can be controlled. Once approval is obtained, the risk can move from “Active Risks” to “Controlled Risks” on the Datix system and the relevant information recorded to document why the risk is controlled, in the same manner for any other risk on the system.

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

Chair's Report

Committee:	Divisional Improvement Forum – Part II			
Data and time:	[INSERT]			
Location:	[INSERT]			
Chairperson and role:	[INSERT]			
Core membership:	[INSERT]			
Attendance:	**Quorate:**	[INSERT]	**Not Quorate:**	[INSERT]
If not quorate, state reason:				

Update on Restricted Circulation Risks:

Specialty	Current Score	Target Score	Risk Theme	Date of Last Review on Datix

Items for positive escalation from Mitigating Action Plans: (where a previously challenging matter has been successfully resolved, assurance can be provided & organisational wide learning might be available for sharing)	1.
	2.
	3.
	4.
Items for negative escalation from Mitigating Action Plans: (where a challenging matter has not yet been successfully	1. Xxx **Actions:**

resolved, assurance cannot yet be provided & organisational wide learning might be available, but the 'parent' committee needs to be aware)	2. Xxx **Actions:**
	3. Xxx **Actions:**
	4. Xxx **Actions:**
	5. Xxx **Actions**:
Name of committee for escalation: (parent committee)	Workforce Committee – Restricted Agenda
Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)	
Date, Time & Location of next meeting:	

Appendix 9 – EQUALITY, DIVERSITY & INCLUSION IMPACT ASSESSMENT

Lancashire Teaching Hospitals NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Governance			
Lead Assessor	Simon Regan			
What is being assessed?	Risk Management Policy			
Date of assessment	05.03.2025			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Board of Directors, Executive Management Team, Risk Management Group members, Corporate and Divisional Governance Leads			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		

Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	The policy sets out a clear standardised process on the management of risk that aims to reduce any risk of inequality in the management of risk.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale
Not applicable	Not applicable	Not applicable

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	√	3. Deliver value for money.	√
		4. Fit for the future.	√

13.2 - MATERNITY AND NEONATAL SAFETY REPORT

REFERENCES

Only PDFs are attached

13.2 - Maternity and Neonatal Safety Report - June 2025 Board copy.pdf

BOARD OF DIRECTORS

Maternity and Neonatal Services Safety Report							
Report to:	Board of Directors			**Date:**	2025		
Report of:	Chief Nursing Officer			**Prepared by:**	Jo Lambert		
Part I				**Part II**	✓		
Purpose of Report							
For assurance	☐	**For decision**	☐	**For information**	☐		

Executive Summary:

The purpose of this report is to provide the Board of Directors with an update report in relation to safe staffing and the safety, quality, assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) for the year 7 reporting period. (1 December 2024 to 30 November 2025). The report covers the period up to May 2025 and the CNST information pack is detailed in appendix 1. To date the service is on track to deliver 9/10 MIS standards, with one declared at risk due to changes to the requirements for the Maternity and Neonatal Voice Partnership (MNVP) lead responsibilities.

The report has already been presented and scrutinised by the safety and quality committee and by the board level perinatal safety champions to provide objective, external challenge and enquiry aligned with the perinatal quality surveillance model.

The perinatal quality surveillance dashboard (PQSD) supplementary information pack is included in Appendix 2. Areas of increased pressure are demonstrated in the red flag reporting, and delay in being assessed within 15 minutes by a midwife in MAS, and a delay in the review by an obstetrician, within 30 minutes in maternity triage, continue to be the highest reporting categories. Analysis of triage performance is discussed in the report and actions related to the tier 2 business case will address this.

There has been an increase in stillbirths in the month of April 2025, however this is not statistically significant, and both cases were Terminations of Pregnancy due to Fetal Anomaly (TOPFA). The 12-month average mean (May 24-April 25) still birth rate is 2.8 per 1000 and 3.2 per 1000 cumulatively since March 2023. These are both lower when compared against the national average of 3.9 per 1000. In the Month of April 2025, sadly there was one case of maternal death at 26 weeks and 3 days. An independent review has been completed by the Medical Examiner (ME), who has confirmed, after discussion with obstetric and critical care medical colleagues, that the cause of death was Amniotic Fluid Embolism. (AFE). The case has been accepted for review by the Maternity and Newborn Safety Investigations (MNSI) and coronial referral was not required.

The service has a current vacancy of 10.99 WTE registered midwives (RM) and once all vacant posts are recruited to, a further 6.86WTE funding will be released, as agreed, in line with the 2025/26 financial planning round. This will align the service with the 2022 Birth Rate Plus requirements. Recruitment to the new Tier 2

obstetric rota has commenced and will have a positive impact on the to see an obstetrician and the associated impact of delays in this area.

The fill rates for Registered Midwives (RM) (89%-day, 93% night) and Maternity Support Workers (MSW) (87% day and 92% night) in April 2025 demonstrates a stable position overall. The lower-than-expected fill rates for support workers during the day continue to be attributed to long term sickness on maternity A and close monitoring of the establishment is ongoing.

The Deputy Divisional Midwifery and Nursing Director, Bereavement Midwife and Lead Research Midwife attended and presented as keynote speakers at the Royal College of Midwives (RCM) conference in April 2025. As a result, several of the team have been approached to present at other sessions, including a student conference.

The service also celebrated international day of the midwife in April 2025 and the teams were gifted a pamper pack, funded by the RCM, in recognition of the work they continue to do to support women and families. This was well received when the leadership team visited the unit on the day.

The service continues to be under pressure but has been relatively stable. Work continues in relation to monitoring and oversight of obstetric safe staffing models, induction of labour and maternity triage workstreams.

RECOMMENDATIONS

The Committee is asked to:

I. Receive and approve the contents of the report noting the scrutiny that has taken place at safety and quality committee.

Appendix

1. Clinical negligence scheme for trust information pack CNST year 7
2. Perinatal Quality Surveillance Supplementary Pack
3. Red Flags Data
4. Induction of labour trend data analysis.

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. 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 up until May 2025. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators for assurance and oversight. In addition, the new Year 7 CNST standards have been published and although safety bundles and monitoring are continuous, new elements are included in the table 1 of the report for information.

2. MATERNITY INCENTIVE SCHEME (MIS)

The CNST 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.

Table 1 provides an overview of the status of all 10 safety standards and provides a high-level summary of the actions taken to meet the requirements and achieve compliance. As per the year 6 maternity incentive scheme, the Integrated Care Board (ICB) /Local Maternity and Neonatal System (LMNS) assurance visits will be undertaken throughout the reporting period and the compliance to each standard will be updated accordingly.

The position against the workstreams set out by the CNST NHS Resolution for year 7 confirms that the service is on track will 9 of the standards with only 1 standard currently at risk. This relates to standard 7 and MNVP attendance at Perinatal Mortality Review Tool meetings (PMRT). The capacity for the MNVP lead to attend is limited due to the commissioning agreement with the LMNS.

A benchmarking exercise is being undertaken to consider how this additional ask can be mitigated. An action plan and escalation are required to meet the standard if this cannot be achieved. Further detail regarding this standard is awaited from the LMNS and an action plan to mitigate the ongoing risk is included in the appendices.

To note, the service is not able to fully validate any of the MIS standards until the LMNS validation and assurance meetings commence. The first of which is planned for June 2025.

Table 1 Details the status of all 10 safety actions

Safety Action 1 PMRT	Standard	Progress	Evidence	Status-on track	Status Validated
	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	Since 1 December 2024, there have been 16 cases reported within the reporting period, 11 of which were eligible for PMRT review. All cases to date have been notified to MBRRACE-UK within seven working days and a review has been started within two calendar months of the death. PMRT should be carried out and 95% of reviews should be started within two months of the death, and a minimum of 75% of multidisciplinary reviews should be completed and published within six months. **NEW for year 7.** 50% of the deaths reviewed should have an external member present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	Appendix 1. Standard 1 No 1,2	On Track	Cannot be validated until the end of reporting period.
A weekly failsafe report is generated to confirm that all standards are met. This is supported by a weekly failsafe meeting. Reports of reviews of all deaths are discussed with the Trust Maternity and Board Level Safety Champions. NHS Resolution use data from MBRRACE-UK/PMRT to cross-reference against Trust self-certifications.					
Safety Action 2 Maternity Services Data Set (MSDS).	Standard	Progress	Evidence	Status	
	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. The year 7 standards are: 1. July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401. MSD405). 2. July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101).	Appendix 1 Standard 2	On Track	Cannot be validated until October 2025
A data report is generated each month and checked prior to submission of the MSDS data. Performance is confirmed at a monthly data meeting by work stream leads.					

Safety Action 3 Transitional Care	Standard	Progress	Evidence	Status	
	Can you demonstrate that you have transitional care (TC) services in place and are undertaking 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 is ongoing. A change in project has been agreed based on highest reason for admission to NICU. The project is based on reducing term admissions associated with respiratory distress. This is the leading cause of admission. An update will be provided in a later report.		On Track	Not yet 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	Standard	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 for 2 tier model is approved and recruitment is ongoing to 3 SAS doctors An obstetric workforce action plan is ongoing.	Shared in previous reports	On Track	Not yet 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 has been utilised since February 2025 and a 1:8 rota for all grades has been achieved. This enables the neonatal service to declare BAPM compliance.	Shared in previous reports	On Track	Not yet 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	On Track	Not yet validated
		Anaesthetic To comply with the anaesthetic medical workforce requirements associated with CNST year 7, 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	On Track	Not yet 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 and reporting will continue to provide assurance.

Safety Action 5 Midwifery Staffing	Standard	Progress	Evidence Source	Status	
	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The funding to meet the midwifery staffing requirements of Birth Rate plus (6.86 WTE) was approved and will be added to the establishment as part of the financial planning for 2025/26 once all vacancies are recruited to. Data collection for the next Birth Rate Plus assessment will commence in May 2025 in line with the 3-year cycle of business.	Bi-annual Safe staffing repots April and October 2025. Appendix 2 Perinatal Quality Surveillance.	On Track	Not yet validated
		The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) All women in active labour receive one-to-one midwifery care		On Track	
		Submit a midwifery staffing oversight report that includes staffing/safety Issues and assurances to the Trust Board every six months		April 25 October 25	

Safety Action 6. Saving Babies Lives V3 (SBLV3)	Standard	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?	The service continues to make progress against the 5 elements of the SBLV3 care bundle and is 91% compliant with the 70 cumulative actions. This compliance will not be reassessed until the next LMNS validation meeting on the 12 June 2025 when an updated position will be provided.	Appendix 1 Safety Action 6 No 1.	On Track	Not yet 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.

Safety Action 7 MNVP	Standard	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 2025. The updated priorities will be jointly approved by the LMNS, service and MNVP in June 2025. **At Risk:** The requirement for year 7 now includes MNVP attendance at PMRT meetings. The capacity to attend is limited due to the commissioning agreement with the LMNS. A benchmarking exercise is being undertaken to consider how this additional ask can be accommodated. An action plan and escalation are required to meet the standard if this cannot be achieved.	Appendix 1 Safety Action 7 Action plan and update	At Risk	Not yet 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.

Safety Action 8 Training	Standard	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 is **96%** overall in April 25. Areas of focus: All staff groups are over 90% except for anaesthetic consultants where 85% of colleagues are compliant. 2 consultants require training to achieve 90% in each staff group. A plan to recover this position is in place. **BASIC NEONATAL LIFE SUPPORT** Compliance of the neonatal and medical newborn life support is tracked in line with MIS year 7. All eligible staff groups are over 90%. including midwifery neonatal medical and nursing including for each eligible staff group. **FETAL MONITORING** – 97% compliance achieved overall for the full day fetal monitoring training. 5 midwives are required to undertake a CTG update session to achieve over the 90% standard.	Appendix 1 Safety Action 8. No 1	On Track	Not yet Validated

Training requirements are tracked via maternity and neonatal safety and quality monthly, and actions taken to ensure all staff groups have achieved 90% by the end of the reporting period. A training report is also submitted to maternity Safety and Quality Committee for oversight.

Safety Action 9 Perinatal Oversight	Standard	Progress	Evidence	Status	
	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Analysis of the Perinatal Quality Surveillance (PQSO) continues monthly through the Safety and Quality committee and is detailed in appendix 1. The Board of Directors will continue to receive the bi monthly report on maternity and neonatal safety. 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 as required. Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting.	Appendix 1 Safety Action 9 No 1 Appendix 2 PQSD	On Track	Not yet Validated

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. The latest you said we did is included in the appendix 1 of the report to demonstrate the ongoing engagement sessions with staff. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff. A Quarterly SCORE card report is collated and shared as a standing agenda item at Safety Champions. This allows triangulation of data to improve patient safety.

Safety Action 10 MNSI	Standard	Progress	Evidence	Status	
	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 1 December 2024 to 30 November 2025	The service confirms that it has reported all qualifying cases to MNSI reporting 100% compliance to the standard. This relates to 3 case overall. 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).	Appendix 1 Safety Action 10. No 1	On Track	Cannot be validated until the end of reporting period
A quarterly report is collated on AMAT to confirm that all qualifying cases have been reported in line with MIS year 7.					

3.0 THE PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

Maternity staffing metrics are displayed on the perinatal quality surveillance dashboard (PQSD) (Appendix 2) each month which is submitted to the Safety and Quality Committee and presented to the Board of Directors for oversight. The statistical process control (SPC) charts provide a data platform for interpreting the statistical significance of data to identify trends and variations in care delivery and outcomes, offering insights into areas where improvements may be needed to reduce disparities in care. By tracking important indicators (e.g. maternal and neonatal health, complications, and mortality rates), the dashboard helps identify areas of concern early, enabling timely interventions to improve outcomes.

3.1 CLINICAL SAFETY INDICATORS

3.1.1 STILLBIRTH

The 12-month average mean (May 2024-April 2025) still birth rate is 2.8 per 1000 and was 3.2 per 1000 cumulatively since March 2023. This is lower when compared against the national average of 3.9 per 1000. There has been an increase in stillbirths in the month of April 2025, however this is not statistically significant, and both cases were Terminations of Pregnancy due to Fetal Anomaly (TOPFA). When the rates were adjusted to exclude cases of termination of pregnancy, the rate is 0 per 1000

All eligible cases continue to be referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) and Perinatal Mortality Review Tool (PMRT).

3.1.2 MATERNAL DEATH

In the Month of April 2024, sadly there was one case of maternal death. The mother was 39 weeks and 4 days gestation and was admitted to the Preston Birth Centre (PBC), the alongside birth centre at Royal Preston Hospital, in the latent phase of labour. Following admission to PBC, a raised temperature and fetal tachycardia was identified, and the mother was referred to the Maternity Assessment Suite (MAS) for continuous electronic fetal monitoring and obstetric review.

Due to concerns regarding the fetal heart rate, a decision was made to perform a category one caesarean section under general anaesthetic (GA). The mother was transferred to theatre, but shortly after the induction of general anaesthetic and delivery of the baby, the mother became unstable and disseminated intravascular coagulation (DIC) was diagnosed. Post operatively, the mother was transferred to the Critical Care Unit (CrCU). Despite maximum care on CrCU, multi organ failure developed and the mother's care was reorientated to palliative care. She died on the 28 April 2025.

An independent review has been completed by the Medical Examiner (ME), who has confirmed, after discussion with obstetric and critical care medical colleagues, that the cause of death is Amniotic Fluid Embolism. (AFE). This incident has been referred to and accepted by the Maternity and Newborn Safety Investigations (MNSI)panel for case review. An update of any associated learning will be included in future iterations of this report.

4.0 SAFE STAFFING INDICATORS

The maternity service continues to be presented with workforce challenges related to national shortages of midwives, despite a comprehensive, forward-thinking workforce plan. The fill rates for Registered Midwives (RM) (89%-day, 91% night) and Maternity Support Workers (MSW) (73% day and 90% night) in April 2025 demonstrate a stable fill rate, albeit that there continues to be a reliance on bank to support the ongoing vacancies.

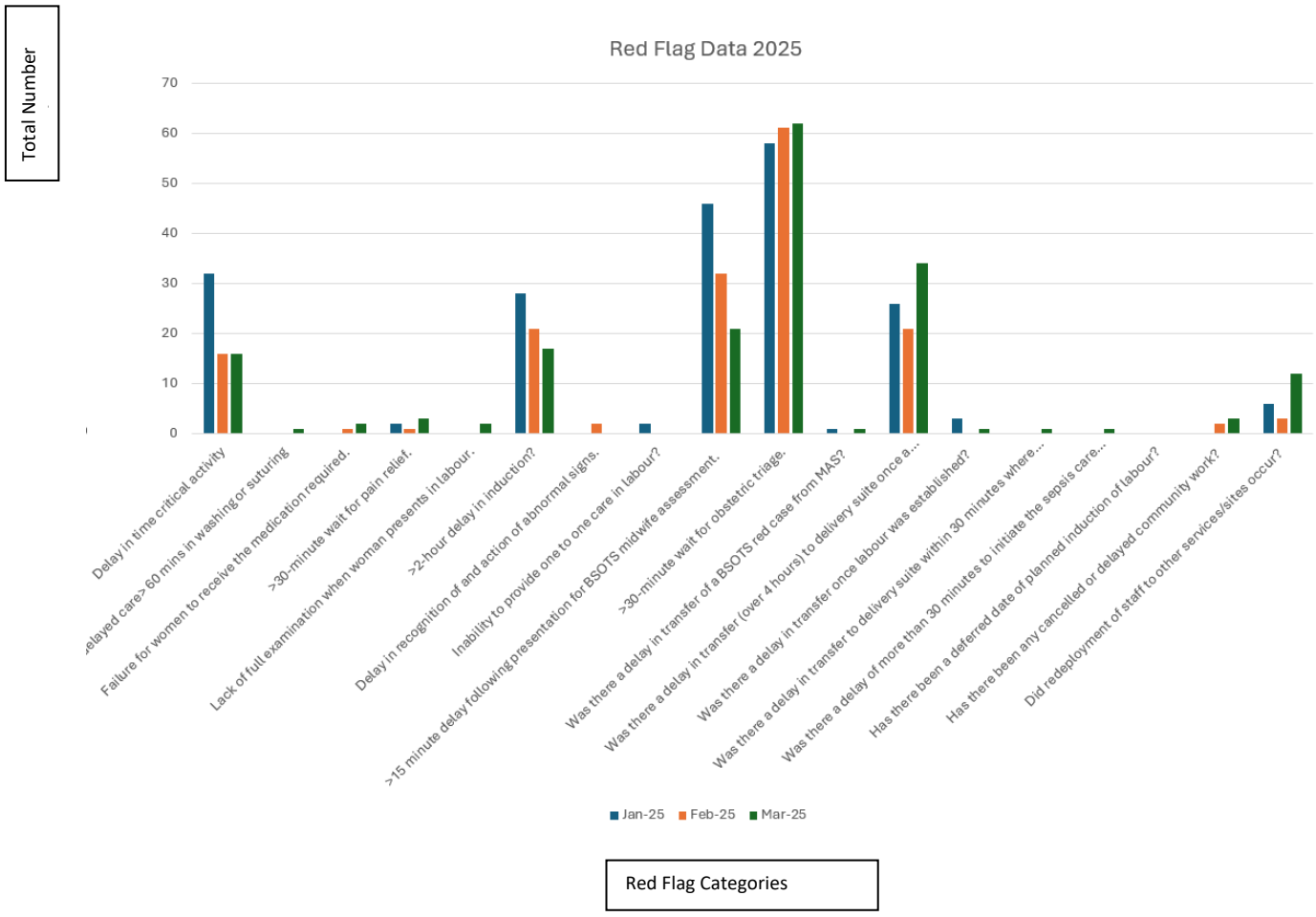
The vacancy for registered midwives is currently 10.99 WTE. The Vacancy Control Process (VCP) is being followed to ensure that safety critical midwifery posts are prioritised. However, there has been some noted impact of the financial grip and control measures that has affected the speed of recruitment processes.

The 10.99 WTE posts are currently in the VCP process, and the service is planning to advertise, shortlist and interview by the end of June 2025. Once the outcome of these interviews is known the service will then forward plan for the next round of recruitment.

5.0 RED FLAGS QUARTERLY SUMMARY.

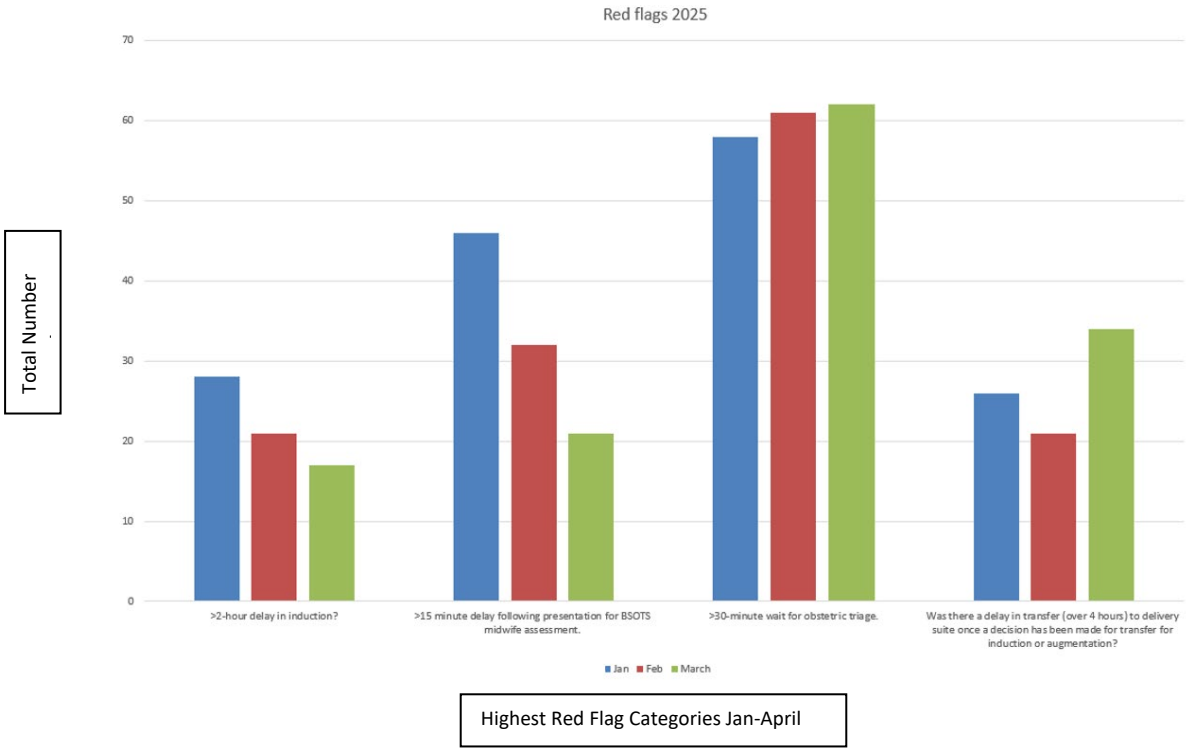
The incidence of maternity red flags continues to be monitored, and incidents are added to the associated risks on the register for additional oversight by the Division. In quarter 4, (Jan-March 2025) the service reported 541 red flag incidents. Chart 1 provides a breakdown of all categories for oversight.

Chart 1 Quarter 4 (Jan-March 2025) Red Flag defined by reporting categories.



The highest number of red flags were reported in the category of delays in review by a midwife in 15 minutes and waiting for a review by an obstetrician in the maternity assessment suite (MAS). Delay in the induction process also features in the 4 highest reporting categories (Chart 2). To note in April 2025, obstetric rota gaps, have affected the response times for obstetric review in triage and this resulted in more delays being reported. (This is discussed later in the report - section 7)

Chart 2 Quarter 4 (Jan -March 2025) Red Flags by highest category.



6.0 PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

In the Care Quality Commission (CQC) action plan update paper provided to the April 2025 Safety and Quality Committee; the outstanding “should do” action for the maternity service regarding midwifery staffing was noted as being complete. This follows the confirmation in the financial planning for 25/26 of the uplift in midwifery staffing accordance with phase 2 of the Birth Rate + recommendations. As a result, the maternity service no longer has any outstanding “should do” actions. However, it is acknowledged that monitoring induction of labour and maternity triage will continue because of their high-risk profile at a local national and regulatory level.

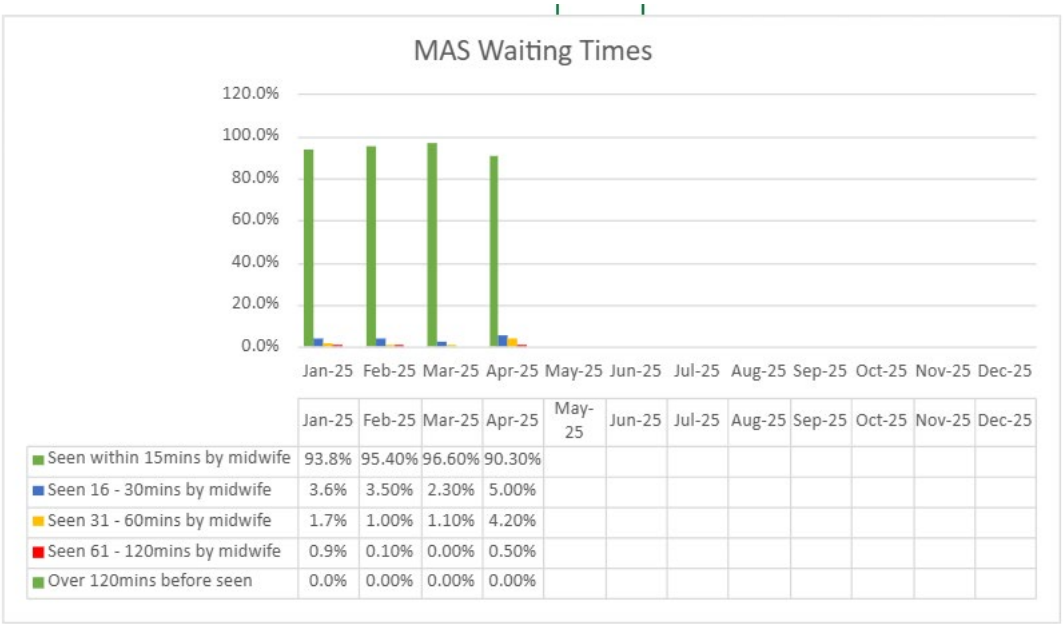
During April 2025, the Trust met with the CQC as part of planned engagement. The maternity service was highlighted for discussion. During the visit an update regarding the exemplar quality improvement work with the Race and Health Observatory was shared. The operations manager for the North Network commended the approach and the achievements by the service.

7.0 MATERNITY TRIAGE

The actions taken to invest in leadership, core staffing and the introduction of maternity support workers have resulted in stabilisation of the triage service. The importance of appropriate obstetric oversight of triage is recognised and following the approval of the tier 2 business case recruitment for 3 SAS doctors has commenced. Once in post they will provide greater oversight of the maternity triage to improve patient experience and safety, especially in time-critical situations.

A breakdown of review times between January and April 2025 is detailed in chart 3 and 4. Chart 3 includes the timeframe for review by a midwife, defined by the Birmingham Symptom-specific Obstetric Triage System (BSOTS) standards between January and April 2025. Although some delays were noted, at least 90% of women were reviewed by a midwife within 15 minutes.

Chart 3 Initial review time for review by a midwife January to April 2025



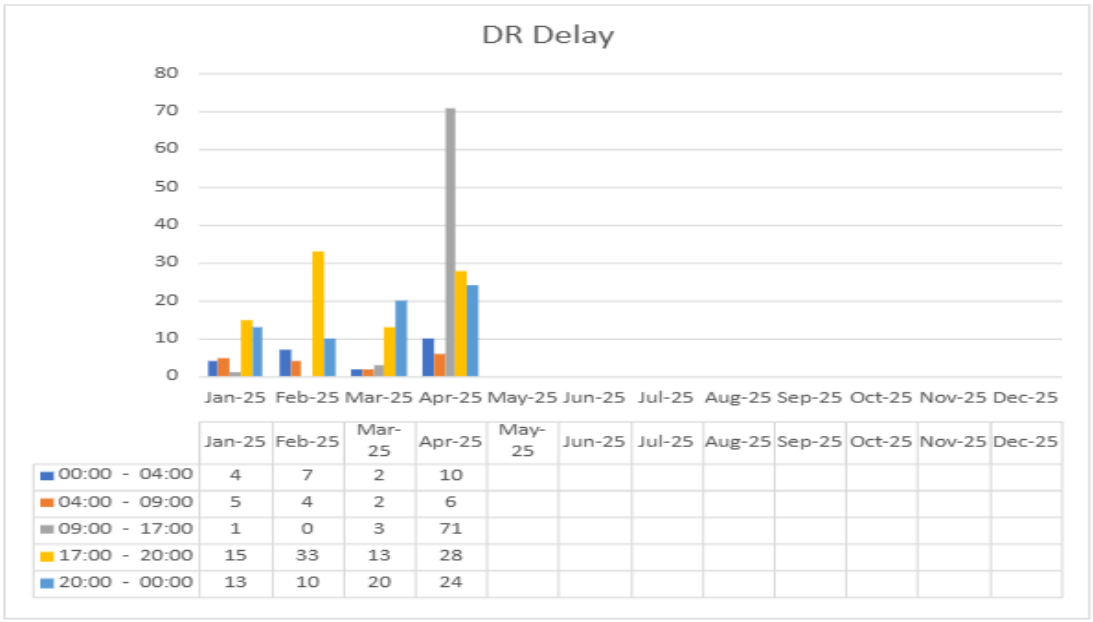
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Seen within 15mins by midwife	93.8%	95.40%	96.60%	90.30%								
Seen 16 - 30mins by midwife	3.6%	3.50%	2.30%	5.00%								
Seen 31 - 60mins by midwife	1.7%	1.00%	1.10%	4.20%								
Seen 61 - 120mins by midwife	0.9%	0.10%	0.00%	0.50%								
Over 120mins before seen	0.0%	0.00%	0.00%	0.00%								

Total Number

Timeframe waiting to be seen

Chart 4 details the times when review by an obstetrician was delayed between the timeframes Monday to Friday. As discussed earlier, there is a significant increase in the number of delays reported in April 2025 and this is associated with the current rota arrangements. These will be resolved as part of the tier 2 recruitment.

Chart 4 Obstetric delay in hours January to April 2025.



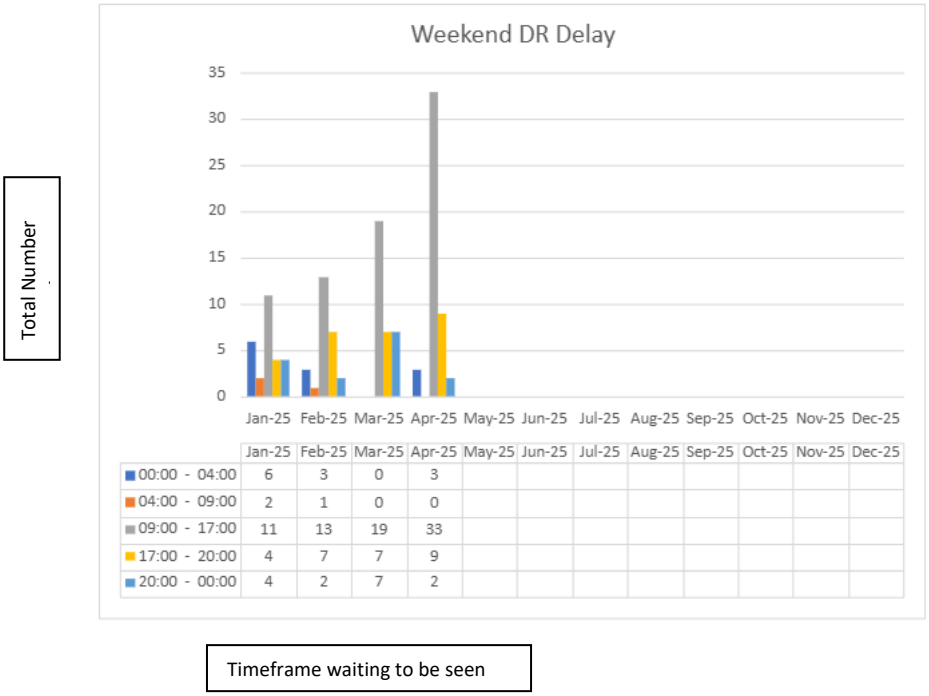
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
00:00 - 04:00	4	7	2	10								
04:00 - 09:00	5	4	2	6								
09:00 - 17:00	1	0	3	71								
17:00 - 20:00	15	33	13	28								
20:00 - 00:00	13	10	20	24								

Total Number

Timeframe waiting to be seen

Analysis of the data demonstrates that most delays occur out of hours and at weekend, or at times when a dedicated obstetrician is not assigned to cover the service. The 2-tier middle grade obstetric rota will address this once these posts are recruited. It is anticipated that the process will take 6 months.

Chart 6 Weekend and out of hours review times for obstetric review.



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
00:00 - 04:00	6	3	0	3								
04:00 - 09:00	2	1	0	0								
09:00 - 17:00	11	13	19	33								
17:00 - 20:00	4	7	7	9								
20:00 - 00:00	4	2	7	2								

8.0 DELAYS IN INDUCTION OF LABOUR

Delays in induction of labour continue to be monitored as a measure of pressure across the service. As part of the ongoing induction of labour improvement plan a service user survey has been launched to obtain feedback about women's experiences of care. Other aspects of this improvement plan include assessing methods of induction of labour, electronic referral and ward and staffing configuration.

During times of high acuity, women who require induction or who are being induced but are delayed, are offered transfer to alternative providers for induction 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 is not underestimated. When this happens, the records are reviewed to consider the impact and potential harm, and all women receive a letter of apology and explanation.

9.0. 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.

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 whenever possible and will continue to be monitored. In April 2025, there were no transfers declined by neonatal unit and 2 declined by maternity services which were related to acuity on the delivery suite at the time of the request.

10. CLOSURES OR DIVERTS

In the month of April 2025 there was one maternity divert. This was due to increased unit acuity over a 4-hour period. During the divert, 2 women were transferred to alternative providers for triage assessment. Both were discharged back to care within the maternity service. A letter of apology and explanation was sent to each woman and there were no incidents of associated harm resulting from the divert.

11. WELL-LED/CELBRATING SUCCESS.

The Deputy Divisional Midwifery and Nursing Director, Bereavement Midwife and Lead Research Midwife attended and presented as keynote speakers at the Royal College of Midwives (RCM) conference in April 2025. As a result, several of the team have been approached to present at other sessions, including a student conference.

The service also celebrated international day of the midwife in April 2025 and the teams were gifted a pamper pack, funded by the RCM, in recognition of the work they continue to do to support women and families. This was well received when the leadership team visited the unit on the day.

12. PERINATAL CULTURE

The SCORE survey local action plan has now been finalised and was shared a previous iteration of this report. Much of the safety intelligence derived from this work is already know to the team from the listening events and staff survey results and therefore several of the actions undertaken have already been commenced.

In addition to this, because of triangulation of feedback received by the Divisional Leadership Team, the Organisational Development Department have been commissioned to perform a further deep dive into the culture across maternity. This work includes anonymous surveys, focus groups and 1:1 interviews with staff has commenced and once completed will be analysed. This will lead to the development of an overarching cultural improvement plan.

13. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report details the position against the workstreams set out by the CNST NHS Resolution for year 7 and confirms that the service is on track will 9 of the standards with only 1 standard currently at risk. Further detail regarding this standard is awaited from the LMNS and the service is not able to validate any of the standards until the LMNS validation and assurance meetings. The first of which is planned for June 2025.

The perinatal quality surveillance dashboard and the red flag reporting indicates areas that require ongoing focus relating to timely review in triage and induction of labour. Both areas within the service are being monitored and tracked.

14. RECOMMENDATIONS

The Safety and Quality Committee is asked to:

I. Receive and approve the contents of the report noting the scrutiny that has taken place at safety and quality committee.

CLINICAL NEGLIGENCE SCHEME FOR TRUST INFORMATON PACK CNST MIS YEAR 7

APPENDIX 1

SAFETY ACTION ONE – PMRT No 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	16/16	
	Surveillance	11/11	
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 1 December 2024 onwards.	On Track	11/11	
REQUIRED STANDARD (Standard C) *			
Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	On track	Commenced within 2 months. 11/11	
		Completed within 6 months: On track.	
REQUIRED STANDARD (Standard D) *			
Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024	April 2025		
	July 2025		
	October 2025		
	December 2025		

SAFETY ACTION ONE PMRT CASES TO DATE No 2

ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 6 months	Actions ongoing
Datix: 182227 PMRT: 96388	35+3	Antepartum Stillbirth	Attended triage a 35 weeks and 3 days with absent fetal movements. FDIU confirmed Via Ultrasound. Reported to MBRRACE with surveillance and initial review completed. No issues with care identified	Yes	96388	Yes	Review completed and published.	All actions completed
Datix: 182442 PMRT: 96441	36+3	Neonatal death	Antenatal care and intrapartum care at another trust, joint PMRT. Neonatal death at RPH following re-orientation of care. Reported to MBRRACE with surveillance and initial review completed.	Yes	96441	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 182834 PMRT ref: 96469	21+4	Neonatal death	Feticide, however reported to MBRRACE as a NND as baby was born with signs of life. Feticide for Cardiac anomalies. Does not require surveillance or review.	Yes	96469	Yes	NA	NA
Datix: 186476 PMRT ref: 96584	24+1	Feticide	Feticide: Congenital anomaly. Reported to MBRRACE Does not require surveillance or review.	Yes	96584	Yes	NA	NA
Datix: 184231 MNSI: MI-039188	26/40	Maternal death	Unexplained maternal death. Case to be reviewed by His Majesty's coroner. Reported to MBRRACE and surveillance, clinician information form and mothers' records sent with Trust AAR to MBRRACE. Accepted for MNSI	Yes	184231	Yes	Awaiting MNSI report	
Datix: 183923 PMRT ref: 96649	39+0	Antepartum Stillbirth	Attended triage on 25.12.2024 with H/O reduced fetal movement from 24.12.2024, FDIU confirmed. Reported to MBRRACE with surveillance and initial review completed. No issues with care identified. Awaiting placental histology.	Yes	183923	Yes	Review completed and published.	All action completed.
Datix: 184488 PMRT ref: 96661	28+4	Antepartum Stillbirth	Antenatal fetal death of twin 1 at routine ultrasound. Under the care of fetal medicine. Twin 1 had exencephaly appearance with additional anomalies. Mother delivered Twin 2 after spontaneous labour at 28 +4. Baby admitted to Yes NICU. Reported to MBRRACE, surveillance and initial review completed. Awaiting Trust review. PMRT to be arranged once histology available	Yes	96661	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 185485 PMRT ref: 96845	40+6	Antepartum Stillbirth	Attended triage with RFM since 10.1.25 evening on 11.1.25. No FH on auscultation. Bedside USS confirmed FDIU, baby was born with no signs of life. Initial review identified learning for the service and a formal investigation is to be commissioned. Reported to MBRRACE, surveillance and review questions completed.	Yes	96845	Yes		Action: plan ongoing
Datix: 185771 PMRT ref: 96909	22+5	Neonatal death	Preterm 22+5, born with signs of life, transferred to NICU and passed away 14.1.25. Will be reported as NND. Reported to MBRRACE. Surveillance and initial review completed. PMRT to be undertaken once investigation complete	Yes	96909	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 186495 PMRT: 97036	33+0	Antepartum stillbirth	Intrauterine fetal death at 33 weeks' gestation. Attended triage with absent fetal movements for 24 hours. Reported to MBRRACE surveillance and initial review completed. PMRT completed.	Yes	97036	Yes	Review completed.	Action plan ongoing
Datix: N/a PMRT: 97145	24+6	Fetocide	Fetocide: Congenital abnormalities. Reported to MBRRACE Does not require surveillance or review.	Yes	97145	Yes	NA	NA

Datix: 190522 PMRT: 97476	23+2	Antepartum stillbirth	PROM and sepsis at 23+2 weeks gestation. Reported to MBRRACE surveillance and initial review completed.	Yes	97476	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 190652 PMRT: 97562	29 + 4	Neonatal death	Neonatal death due to prematurity and sepsis. Reported to MBRRACE surveillance and initial review completed.	Yes	97562	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 194158 PMRT: 98023	35+1	Neonatal Death	Neonatal Death at Derian House after re-orientation of care. Reported to MBRRACE surveillance, to await review.	Yes	98023	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	
Datix: 194450 PMRT: 98031	16+4	Neonatal Death	Neonatal death, baby born at 16 weeks and 4 days gestation and shown signs of life for 20 minutes. Reported to MBRRACE Does not require surveillance or review.	Yes	98031	Yes	NA	NA
Datix: N/a PMRT: 98286	28+1	Fetacide	Fetocide: Abnormalities twin pregnancy. Reported to MBRRACE Does not require surveillance or review.	Yes	98286	Yes	NA	NA
Datix: 197102 PMRT: S045 MNSI: MI941706	39+4	Maternal Death	Maternal death, 39+4 Category 1 caesarean section for fetal distress, transfer to ICU, Reported to MBRRACE surveillance and initial review completed.	Yes	S045	Yes	Awaiting MNSI report	
Datix: 199030 PMRT: 98587	29+2	Neonatal death	Neonatal death, following from planned re-orientation of care. Baby Premature, suspected sepsis, respiratory distress syndrome, cleft lip, hyperkalaemia, anaemia, IVH/Parenchymal haemorrhage (IVH Grade 4), Acute Kidney Injury. Reported to MBRRACE surveillance, initial review to be arranged.	Yes	98587	Yes	Review ongoing, deadline not yet met. PMRT planned with deadline for publishing	

SAFETY ACTION TWO MSDS

Trust results for Maternity incentive scheme (CNST) Year 7: Safety Action 2

NHS

Title | Summary | **Scores Breakdown** | Metadata | Other DQ Priorities | Useful Links | FAQs

The tables below contained the detailed results for the selected Trust for the two measures that make up Safety action 2, covering Birthweight and Ethnicity data quality.
The full description and construction for each of the measures is available on the Metadata page in this scorecard.

Select organisation: LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Select reporting month: February 2025

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

CNST: Safety Action 2 results for LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST for February 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	325	325	100.0	Passed

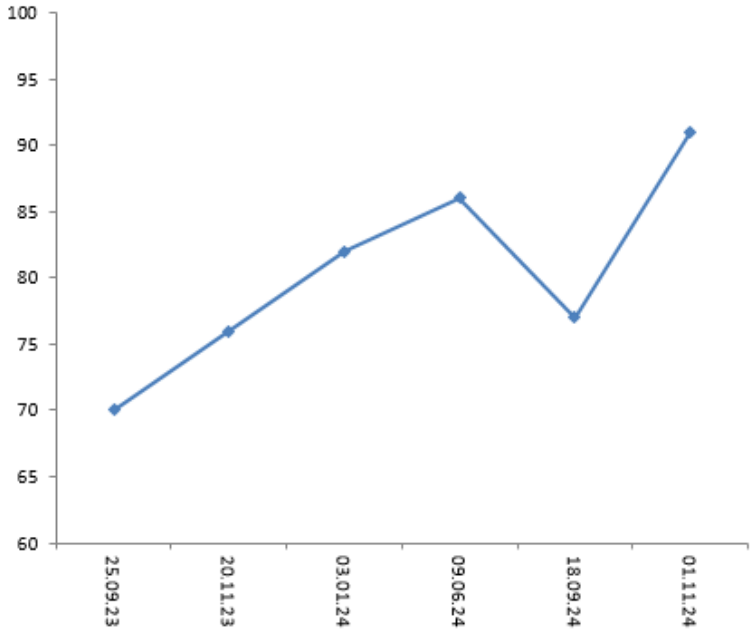
Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	360	365	98.6	Passed

Pass rate: 90%

SBLCBv3 implementation progress to date



Implementation per element – April 2025

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

SAFETY ACTION 7 MNVP ESCALTION ACTION PLAN No 1

Version	Date
V1	16.05.2025

Action Plan – Standard 7 Maternity Incentive Scheme Year 7.

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
Lead Officer:	Joanne Lambert
Position:	Deputy Divisional Midwifery and Nursing Director
Tel:	01772 524307
Email:	Joanne.lambert@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 Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**Evidence of MNVP infrastructure being in place from your LMNS/ICB including all the following:** **• Budget with allocated funds for IT, comms, engagement, training and administrative support.** **If the above evidence of an MNVP commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.**	Escalation via Maternity and Neonatal Safety Report	Deputy Divisional Midwifery and Nursing Director	30.05.2025	16.05.2025 Escalation and action plan to be included in the maternity and Neonatal safety Report presented to Safety and Quality Committee on the 30.05.2025.	
		Escalation to the ICB/LMNS via validation visits	Deputy Divisional Midwifery and Nursing Director	12.06.2025	16.05.2025 Divisional Midwifery and Nursing Director to escalate as part of the LMNS assurance and validation meeting	
		Escalation via the L&CS Board Slide update	Divisional Midwifery and Nursing Director	06.06.2025	16.05.2025 Slide to include escalation in relation to resources available to meet requirement to attend PMRT.	
		Benchmarking exercise to review number of hours required to for the MNVP Lead as a quorate member of trust governance to attend speciality/divisional/directorate level including all the following: • Safety Champion meetings • Maternity quality and safety meetings • Neonatal quality and safety meetings • PMRT review meeting • Patient safety meeting • Guideline committee	Deputy Divisional Midwifery and Nursing Director	30.06.2025	16.05.2025 Benchmarking exercise completed and returned to LMNS. Meeting planned for 05.06.2025 to discuss further.	
		Following benchmarking exercise LMNS to reconsider meeting attendance to realign allocated funding to local level meetings.	LMNS/ICB	30.06.2025	16.05.2025 LMNS Action. Included for oversight	

		Ensure that alternative arrangements are in place to hear the service user voice until resources are re-aligned. Bereavement midwife to continue to support family perspectives during the PMRT process.	Deputy Divisional Midwifery and Nursing Director	30.06.2026	16.05.2025 Robust and established process in place via bereavement midwife to ensure family questions are answered and women have an advocate.	

Preston, Chorley & South Ribble Maternity & Neonatal Voices Partnership **2nd May 2025/Reporting month April 2025**

LSC LMNS Board Report

MNVP Workplan – Exception report

Workplan Priority area	Deliverable	RAG	Update/Rationale
Equity and Equality .To ensure that the MNVP are engaging with ethnic minority and seldom heard families within the community to ensure feedback is delivered to support the understanding behind why these service user groups have poorer outcomes from their birth experience.	Ensuring that we are accessing and targeting engagements within areas where seldom heard and ethnic minority families live. Ensuring that we have awareness and attendance at any events within these.		Awareness that the engagement with these groups have a low attendance or lack of willingness to engage to share feedback. Currently awaiting contact with Red cross who hold asylum seekers groups to support families in the local community and potential for engagement.
Recruiting volunteers	Once volunteers are recruited – organisation of more engagements events and reaching out further within the community to gain more feedback and greater response levels.		Still only one volunteer on board currently and their availability is increasing limited due to their other commitments causing difficulties establishing an initial shadowing session which has still not been confirmed to move forwards to independent engagements. Healthwatch has now confirmed separate training will be held for MNVP volunteers due to limited capacity
Birth Trauma Project	Gain insight and outreach to neonatal families through the birth trauma funding to establish main needs and identify how the MNVP can integrate these families well into the MNVP for all future feedback.		Roadshow initially delayed 24/25 due to awaiting funding. Meeting has been organised and confirmed for May due to lack of capacity for all MNVP's / ODN and PAG prior to this due to holidays. The meeting will discuss potential questions to use in phase 1 of the project.

Activity in last month	Planned activity next month
Maternity Assessment Suite Visit and engagement	Neonatal Engagement Questionnaire meeting
Virtual attendance at Gypsy, Roma & Traveller Infant feeding resource launch	Hearing the voice of bereaved parents MNVP webinar
Transforming Health through personalised care strategies webinar	Work Plan Meeting 25/26
Free From Harm for Healthcare Professionals webinar	MNVP Summer Event and Quarterly Meeting
	Engagement Multiple Birth Clinic
	Engagement event with Healthwatch to Bamber Bridge Family fun day

SAFETY ACTION STANDARD 8 TRAINING MATERNITY AND NEONATAL NO 1

April 2025	MIDWIVES	CONSULTANTS	DOCTORS	OVERALL
GAP/GROW	**97%** *190 out of 196*	**90%** *9 out of 10*	**94%** *15 out of 16*	**96%** (increase 1%) *214 compliant out of 222*
Fetal Monitoring training Attendance at full day fetal monitoring training	**97%** *184 compliant out of 189*	**80%** *8 compliant out of 10*	**100%** 18 *compliant out of 18*	**97%** (Static) *210 compliant out of 217*
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**94%** *178 compliant out of 189*	**90%** *9 compliant out of 10*	**100%** *16 compliant out of 16*	**94%** (static) *203 compliant out of 215*
Human Factors (attended PROMPT)	**95%** *188 out of 196*	**100%** *10 out of 10*	**96%** *26 out of 27*	**96%** (increase 1%) *224 compliant out of 233*

April 2025	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETIST CONSULTANTS	ANAESTHETIST ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT) Inc Neonatal Life Support	**95%** 188 out of 196	**100%** 10 out of 10	**96%** 26 out of 27	**85%** 11 out of 13	**100%** 9 out of 9	**98%** 54 out of 55	**96%** (static) *298 compliant out of 310*
Pool Evacuation	**95%** 188 out of 196	**100%** 10 out of 10	**93%** 25 out of 27			**98%** 54 out of 55	**96%** (increase 2%) *298 compliant out of 310*

April 2025	NICU Nurses	NICU nursery nurses	CONSULTANTS	ANNP's	JUNIOR DOCTORS below ST5	JUNIOR DOCTORs ST5 and above	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	**96%** *73 compliant out of 77*	**100%** *7 compliant out of 8*	**100%** *9 compliant out of 9*	**100 %** *5 compliant out of 5*	**100 %** *7 compliant out of 7*	**100%** *7 compliant out of 7*	**96 %** *108 compliant out of 113*

Always Safety First

Maternity and Neonatal Safety Champions

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

You Said…We Did…

Visit to Chorley Birth Centre

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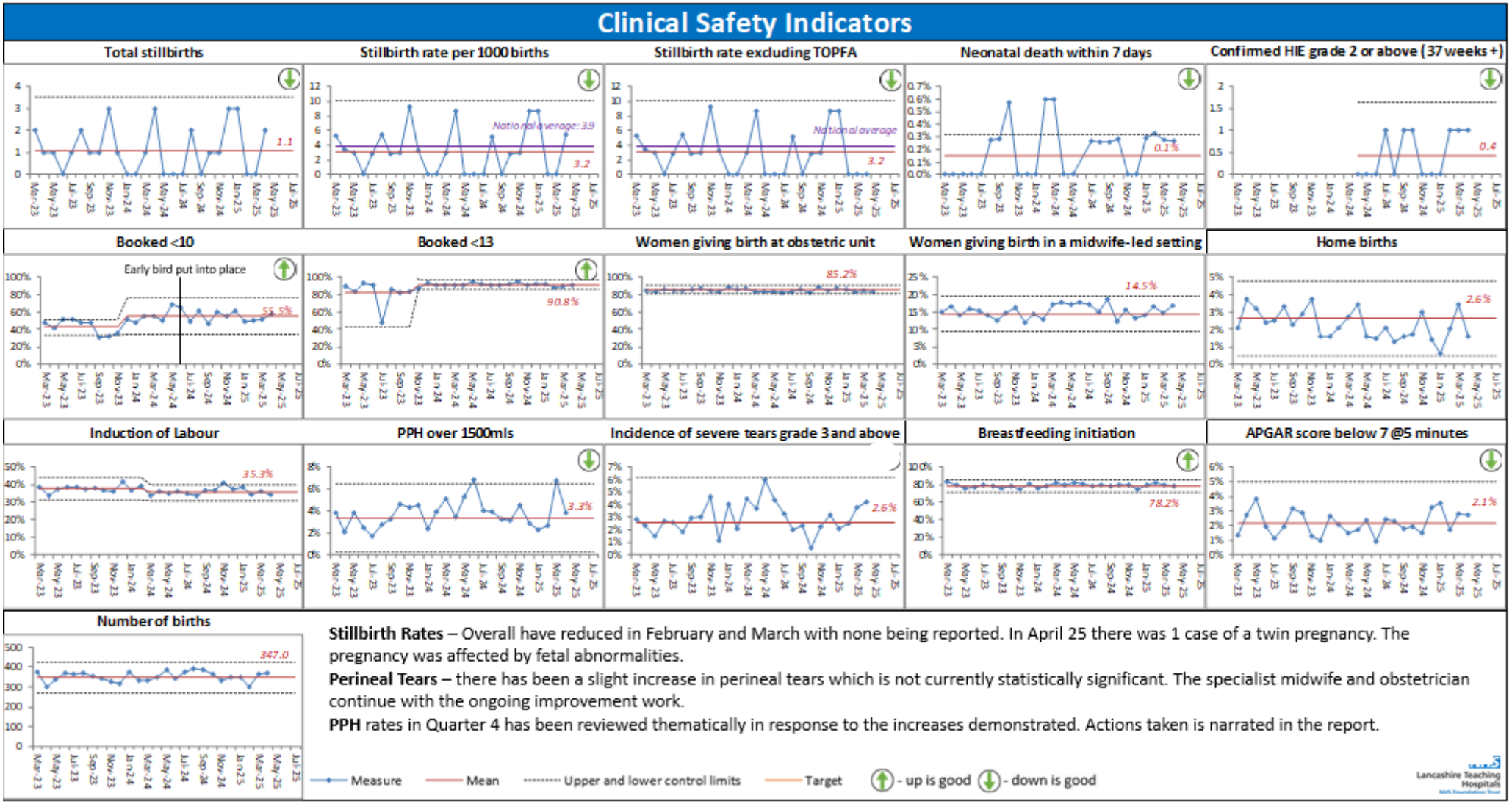
The signage on the road is weak to find the birth centre, patients and ambulances feed this back.	Additional signage is under design on both sides of the junction. This will be larger and have additional information around access and parking.
The Wi-Fi is unreliable, badgernet drops out and is slow and ipads are sometimes difficult to access.	A Digital Functionality Group has been established with midwifery and IT representation to identify problems, solutions, and any incidents. Wifi testing has been undertaken to ensure signal quality and no issues found.
There is not enough equipment now more rotation takes place through community, more bags, bilirubin meters, and scales would help reduce lost time	Community staff are advised not to take essential equipment from Chorley Birth Centre and are redirected to the community stores. Additional equipment has been ordered for community –
Birth centre is not always seen as a priority when other units are busy and whilst understand why staff are moved this has an impact on how people feel about how birth centres are valued. Agreed the next investment in midwives should be for delivery suite to reduce movement of staff and maintain home and birth centre options.	Birth centres and homebirth teams are staffed to establishment. Communications have been shared with unit coordinators to ensure support is provided to homebirth and birth centre services by the main unit when required via a decision tree and actions/escalations required.
Leadership of the unit managers working together is good, feel supported by the senior leaders they listen to us and try there best.	Regular opportunities for ward managers to meet across sites at Birth Forum and Midwifery Senate and with Matron at Midwifery led planning and one to ones.
Leadership days bringing all staff together across the service have helped us connect and understand one another more. Very positive.	There have now been 5 leadership days delivered in 2024 and early 2025.
Number of students makes it hard to provide a good experience at times, worry we don't give them a positive experience.	A new roster template has been developed to allocate tiles to staffing requirements. For example, there is only 1 tile per shift per day that can be rostered for students. This is to ensure all shifts are utilised 24/7. The number of students per day has been agreed recently with Matrons and Managers
The rotation of staff is good so that more staff can move to work in different areas of the service, but we prefer to stay in our own areas to get to know and develop the skills we need in those areas.	Core staff are rostered within each area to provide stability and expertise. Rotational Midwives move around all clinical areas and have an allocated community clinic which maintains intrapartum and community skills for midwifery led and complex pregnancies.
Newly qualified staff very well supported through supernumerary period, worry about the transition to independent practice may happen too quickly.	The preceptorship programme offers a graduated integration to birth centres and community. There is also a period of supernumerary in each of the clinical areas.

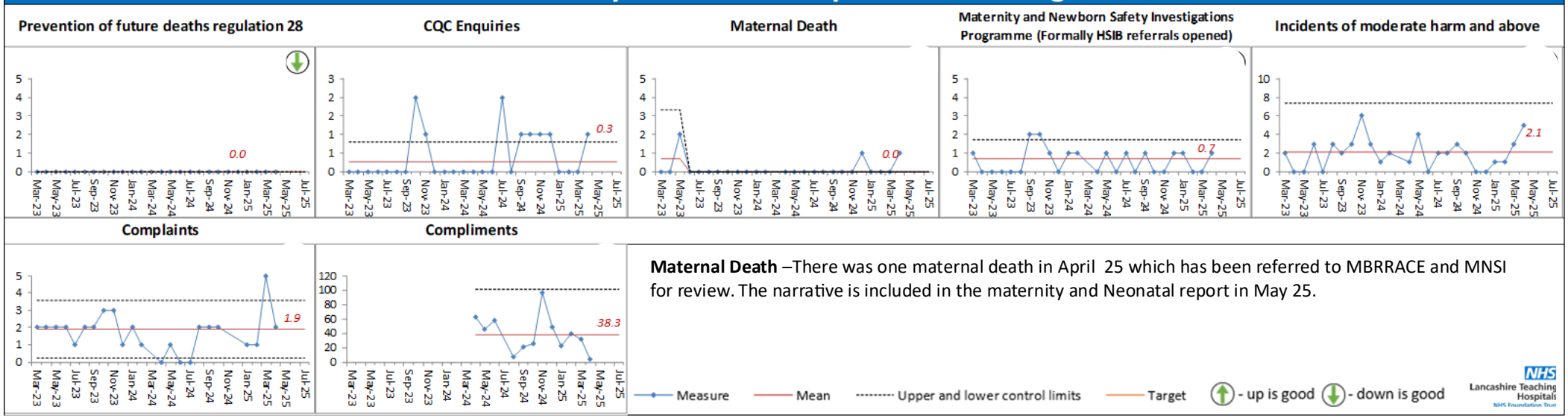
STANDARD 10. CASES REPORTED FROM DECEMBER 1, 2024 TO APRIL 2025. No 1

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of MNSI investigation	Final MNSI report sent to legal team.	Duty of Candour.
039925 AF 3.01.2025	The Maternity service was informed on the 27.12.24 of a maternal death at 26 weeks of pregnancy. The woman was known to the maternity services and there was a known history of domestic abuse which was disclosed to have occurred by a previous partner between 2018-2020, The case has been referred to the coroner, MBRRACE-UK have been notified, and the case has been referred to MNSI and accepted.	No	NA	Investigation ongoing	NA - ongoing	Yes
041480 UD 16.4.25	The mother had a low-risk pregnancy, this was her first baby, and she spoke no English. She presented at the Maternity Assessment Suite, on her due date of the 16.4.25, with PV bleeding and abdominal pain. She was advised to come in and on admission, noted to have an abnormal CTG. The mother was transferred to the Delivery suite, where she gave birth by Emergency CS. The baby was born with a low HB, indicative of a fetal-maternal haemorrhage that likely occurred in the antenatal period. The baby did not meet the criteria for therapeutic cooling and the MRI results demonstrate that the baby likely has severe HIE. The case was referred to MNSI.	Yes	Yes	Investigation ongoing	NA - ongoing	Yes
041706 RR 29.4.25	The 28-year-old mother, presented to the Birth Centre in her first pregnancy. She was admitted in early labour at 39 weeks and 4 days gestation on 26.4.2025. On admission to the birth centre the mother was noted to have a temperature and was referred to the maternity assessment suite (MAS) for continuous electronic fetal monitoring. Once seen in MAS she was sent up to delivery suite for ongoing care. After the transfer to delivery suite, sepsis screening was completed and intravenous antibiotics was administered, due to ongoing concerns with the fetal heart rate a decision was made for a category one caesarean section under general anaesthetic. The mother was transferred to theatre and following the induction of general anaesthetic and delivery of the baby, the mother became unstable. Disseminated Intravascular Coagulation (DIC) was diagnosed, and the mother was transferred post-operatively to the Critical care unit (CRCU). Unfortunately, despite extensive care on CRCU, multi-organ failure developed, and the mothers care was reorientated to palliative care, with the family updated. At the independent review, the medical examiner has confirmed that cause of death is due to an amniotic fluid embolism.	No	NA	Investigation ongoing	NA - ongoing	Yes

PERINATAL QUALITY SURVIELLENCE DASHBOARD
APPENDIX 2


Clinical Safety Indicators
Total stillbirths
1.1
Stillbirth rate per 1000 births
National average: 3.9
3.2
Stillbirth rate excluding TOPFA
National average
3.2
Neonatal death within 7 days
0.1%
Confirmed HIE grade 2 or above (37 weeks +)
0.4
Booked <10
Early bird put into place
55.5%
Booked <13
90.8%
Women giving birth at obstetric unit
85.2%
Women giving birth in a midwife-led setting
14.5%
Home births
2.6%
Induction of Labour
35.3%
PPH over 1500mls
3.3%
Incidence of severe tears grade 3 and above
2.6%
Breastfeeding initiation
78.2%
APGAR score below 7 @5 minutes
2.1%
Number of births
347.0
Stillbirth Rates – Overall have reduced in February and March with none being reported. In April 25 there was 1 case of a twin pregnancy. The pregnancy was affected by fetal abnormalities.
Perineal Tears – there has been a slight increase in perineal tears which is not currently statistically significant. The specialist midwife and obstetrician continue with the ongoing improvement work.
PPH rates in Quarter 4 has been reviewed thematically in response to the increases demonstrated. Actions taken is narrated in the report.
Measure
Mean
Upper and lower control limits
Target
- up is good
- down is good
Lancashire Teaching Hospitals

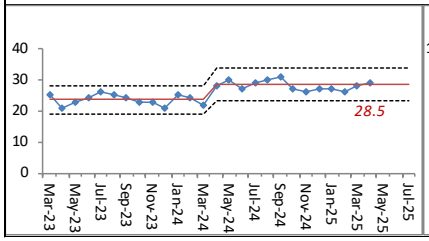
Perinatal Quality Governance Experience and Regulation



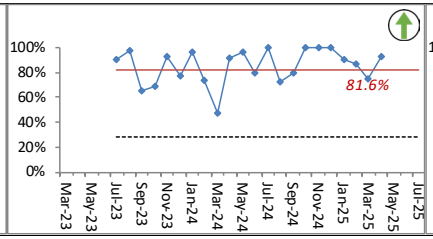
Maternal Death –There was one maternal death in April 25 which has been referred to MBRRACE and MNSI for review. The narrative is included in the maternity and Neonatal report in May 25.

Safe staffing indicators

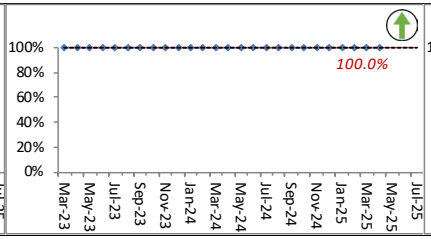
Births per Funded Clinical Midwife WTE



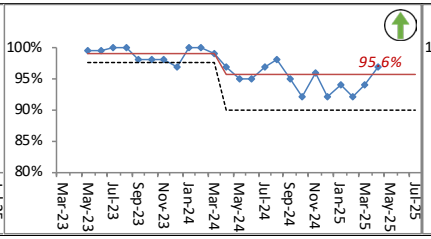
Neonatal Nurse Staffing compliance to BAPM



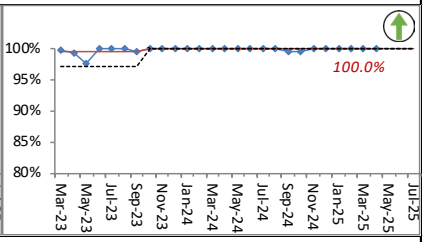
Supernumerary status of DS coordinator at the start of every shift



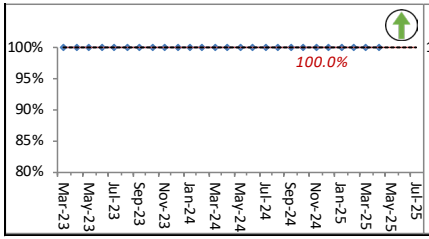
HDU trained per shift



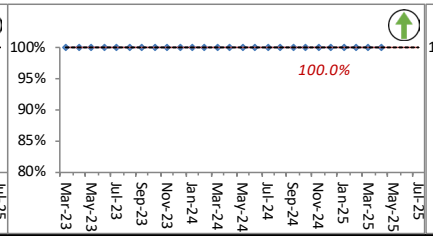
One-to-one care in labour in Delivery Suite



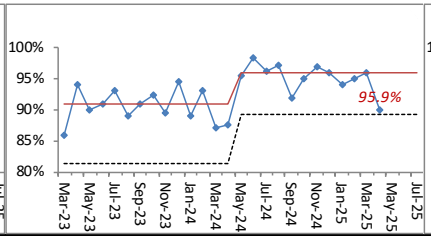
One-to-one care in labour in Preston Birth Centre



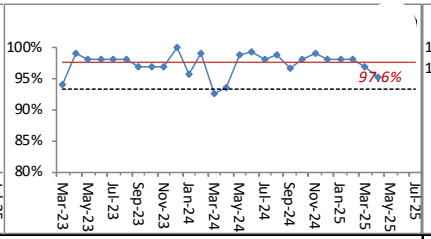
One-to-one care in labour in Chorley Birth Centre



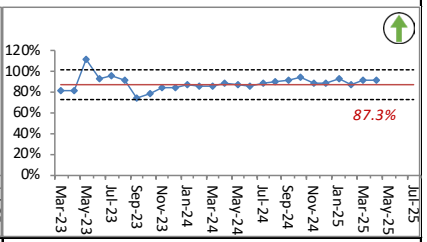
Maternity Triage BSOT standard (15min)



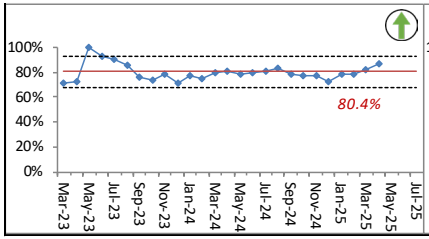
Maternity Triage NICE standard (30 min)



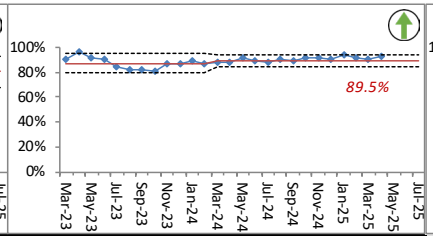
Fill rate RM Day



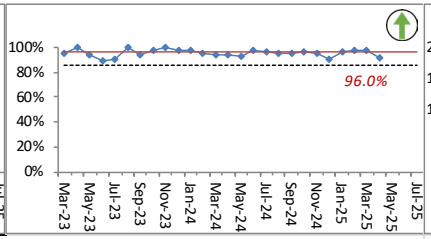
Fill rate MSW Day



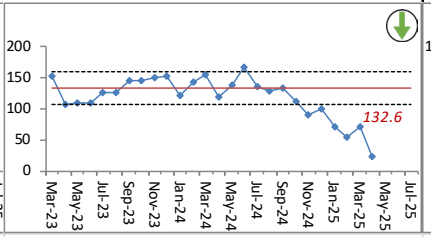
Fill rate RM Night



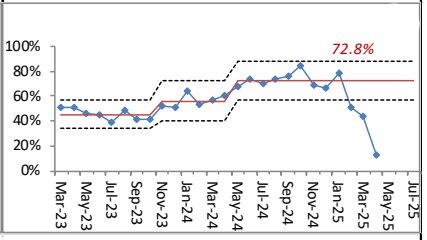
Fill rate MSW Night



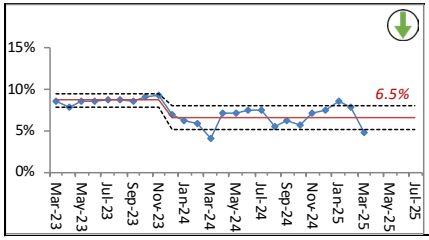
Registered Midwife shifts sent to agency



Registered Midwife Agency hour fill rate



Staff sickness rate



Births per funded midwife has been recalculated in month based on staffing post. There is no mandated standard associated with midwife to birth ratio. This parameter remains useful to track over time **aligned against recruitment and** vacancies.

Shifts sent to agency The number of shifts sent to agency is reducing which is reflective of the financial control measures in place and the capped rate to align to other providers in ICB

Agency Fill rates the number of shifts being filled by agency continues to be overseen by the DMND as required. Bank shifts are being utilised in preference over bank

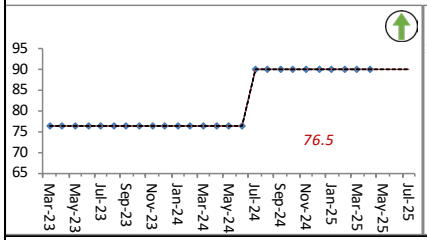
Sickness absence has started to decrease over the last 2 months. This is a significant reduction in the month of March 25. **Supernumerary status and 1:1 care in labour** continues to be 100%. This provides assurance that despite staffing pressures the service continues to prioritise safe staffing.

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

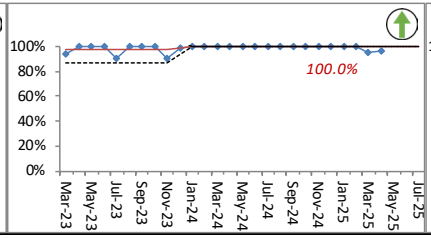
Lancashire Teaching Hospitals NHS Foundation Trust

Obstetric Medical Staffing

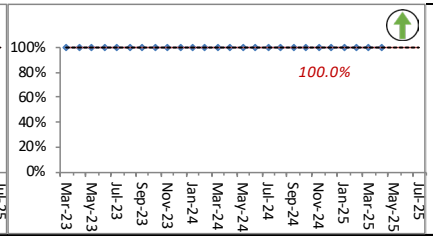
Number of Consultant hours on obstetric unit



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 90 hours cover for acute care. The 2-tier roster has been approved, and recruitment is ongoing.

RCOG attendance remains over 90% in all months, there have been 2 occasions in quarter 4 when the consultant did not attend. This compliance continues to be monitored. MIS year 7 requires that the service demonstrated over 80% compliance for 3 months within the reporting period. This standard is consistently achieved overall.

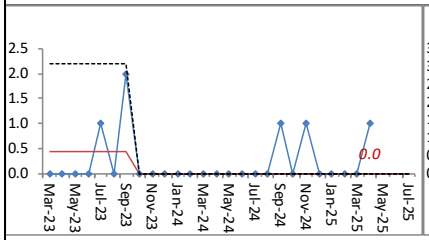
Consultants fill rates for acute care continues to be 100%

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

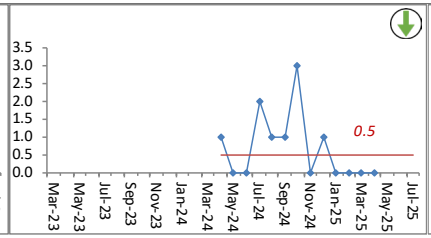
NHS Lancashire Teaching Hospitals NHS Foundation Trust

Clinical Escalation

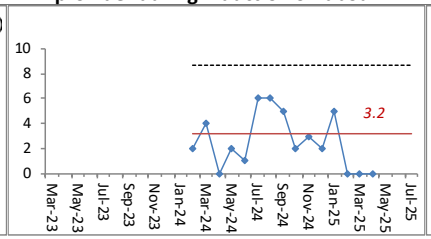
Maternity Diverts



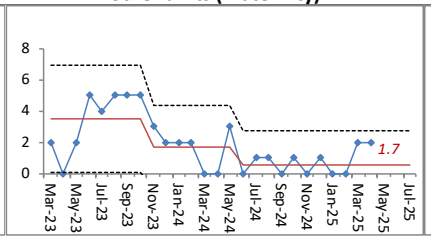
Number of times home birth service stood down



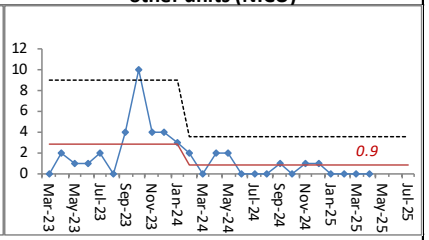
Women who transfer to an alternative provider during induction of labour



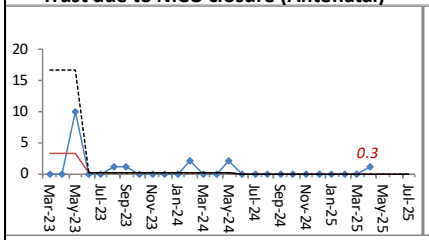
In- utero transfers declined to accept from other units (maternity)



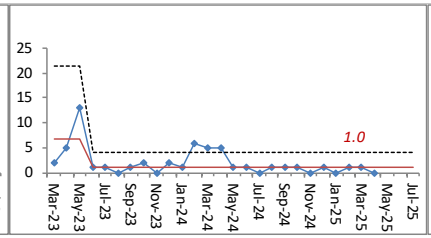
In- utero transfers declined to accept from other units (NICU)



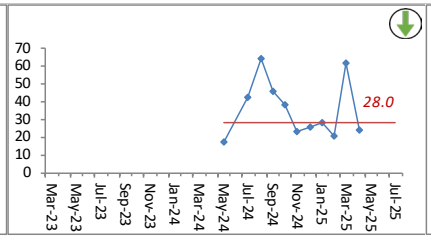
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)



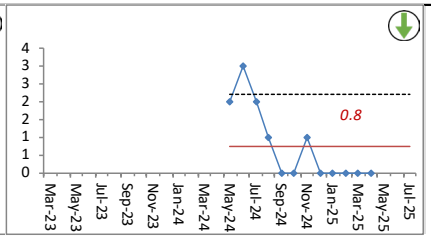
NICU Closure



Delay in inductions (New)



Elective sections stood down (New)



In-Utero Transfers (IUT) IUT decline rates continue to be consistently lower than previous months neonatal services. There has been a slight increase in the cases declined by the maternity service in month. Higher acuity and increased complexity rates have affected the ability to accept all cases.

Maternity Diverts There was one maternity divert that occurred in April 25. The decision was taken in response to high acuity over a 4-hour period to maintain safety. 2 women were transferred to alternative providers for triage. Both women returned to Lancashire Teaching for the remainer of their care.

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

APPENDIX 3 RED FLAGS MARCH 2024 TO APRIL 2025

Red flag Reporting Metrics	Mar 24	April 24	May 24	Jun 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25	April 25
Delay in time critical activity	38	16	24	36	18	41	61	40	44	59	32	16	16	117
Missed or delayed care> 60 mins in washing or suturing	1	0	2	1	2	0	0	1	0	1	0	0	1	0
Failure for women to receive the medication required.	0	0	0	3	1	0	1	0	0	1	0	1	2	0
>30-minute wait for pain relief.	0	0	4	3	3	0	2	0	0	0	2	1	3	1
Lack of full examination when woman presents in labour.	1	0	0	2	1	0	4	0	0	0	0	0	2	0
>2-hour delay in induction?	18	9	16	20	22	42	34	21	9	7	28	21	17	5
Delay in recognition of and action of abnormal signs.	1	0	2	0	1	0	1	1	0	0	0	2	0	0
Inability to provide one to one care in labour?	0	0	3	4	4	1	4	0	0	0	2	0	0	1
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)	29	43	38	20	46	24	75	42	24	23	46	32	21	82
>30-minute wait for obstetric triage.	12	30	31	43	47	20	56	41	46	47	58	61	62	156
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	1	2	0	0	0	0	1	0	1	0	1	1
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)	12	5	0	30	30	28	25	20	14	19	26	21	34	17
Was there a delay in transfer once labour was established? (New parameter Oct 22)	2	0	3	3	1	1	2	0	0	0	3	0	1	1
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	2	0	0	0	0	0	0	0	0	1	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	1	0	1	1	1	0	2	0	0	0	0	0	0	1
Has there been any cancelled or delayed community work? (New parameter Oct 22)	28	95	12	13	25	5	28	4	0	0	0	2	3	2
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)	2	9	7	12	17	9	12	8	2	0	6	3	12	9
Total numbers of red flags	**146**	**207**	**145**	**195**	**219**	**171**	**307**	**178**	**140**	**157**	**204**	**160**	**177**	**394**

APPENDIX 4 INDUCTION OF LABOUR PERFORMANCE APRIL 2024-MARCH 2025.